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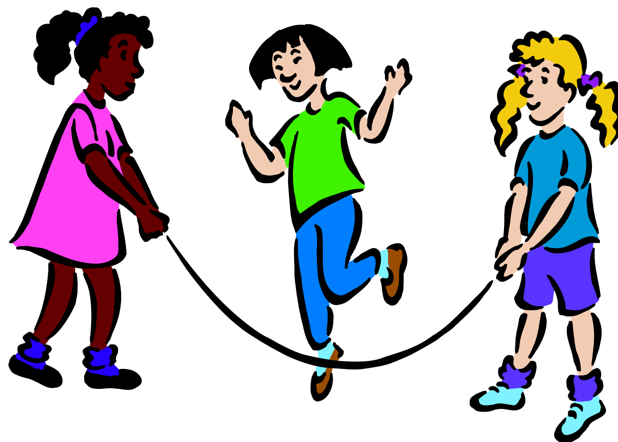
Health Insurance Coverage for Merced County Low-Income Children

A Feasibility and Planning Study



Prepared for the

Merced County
Public Health Department
and the
Merced County Children's Health Initiative
Steering Committee

By

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Pacific Health Consulting Group
July, 2005

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Executive Summary

Merced County faces a crisis that affects thousands of its most vulnerable residents—its children. Approximately 8,000 low-income children lack health insurance. This places them in jeopardy of not receiving needed health and dental care services on a timely basis, if at all. This report examines how Merced County, building on the momentum already underway, can address the problem of being uninsured. Of the 8,000 uninsured children, this report found that 2,800 children are not eligible for either of the existing public health insurance coverage programs, Medi-Cal or Healthy Families. Fortunately, many other California counties have found the energy, creativity and financial support to develop a low cost insurance product to serve uninsured children.

This study also identifies that an estimated 5,200 uninsured children in Merced County are eligible for Medi-Cal (1,920) and Healthy Families (3,280), but are not enrolled. In the past five years, a number of California counties have mounted campaigns, called "Children's Health Initiatives," CHIs, that combine a concerted effort both to identify and enroll children who are eligible for existing public health insurance programs and to develop a health insurance program for low-income children who do not qualify for Medi-Cal or Healthy Families. The report describes the opportunities available to Merced County to address the lack of health insurance for thousands of its children. Like all counties which have considered the development of a CHI, Merced County will face common, as well as, unique opportunities and challenges.

Health Insurance and Access to Care Are Important

The lack of health insurance leads to lower access to care and ultimately, poorer health outcomes. Uninsured children are at least 70% more likely than insured children to not receive medical care for such common childhood illnesses as sore throats, ear infections and asthma. These conditions may have serious and irreversible consequences if left untreated. Uninsured children who are injured are 30% less likely than insured children to receive medical treatment.[1] The percentage of children

[1] Children's Health-Why Health Insurance Matters, Kaiser Commission on Medicaid and the Uninsured, May 2002, www.kff.org.

reporting any unmet need or delayed care in the past six months decreased with enrollment into insurance.

- Uninsured children are almost three times as likely as insured children to have an unmet health care need within the past year.[2]
- Uninsured children are approximately twice as likely as insured children to not receive care from a physician for acute earaches, recurrent ear infections, asthma, or sore throat with a high fever.[3] These can lead to hearing loss, central auditory processing disorder and life-threatening emergencies.
- Uninsured children are 30% less likely than insured children to have received medical care when they are injured.[4]
- Children living in low-income areas have two to four times as many preventable hospitalizations as children living in high-income areas. These rates are likely to be due to poorer general health status, poorer access to preventive and routine care when needed, as well as to lack of insurance among low-income families.[5]
- Uninsured children with chronic medical conditions have been found to have insufficient access to routine medical care. According to a national survey sponsored by the Robert Wood Johnson Foundation, 17% of uninsured children did not receive medical treatment needed for chronic illness such as asthma, diabetes or other conditions serious enough to keep a child from functioning at school.[6]

Local Leadership

Serious and committed efforts to increase the percentage of Merced County residents with health insurance have been underway for the past few years. In January 1999, the Health Care Access Coalition (HCAC) began mounting a concerted effort to enroll eligible individuals in Medi-Cal through a countywide Medi-Cal outreach program. In addition to representatives from the county Human Services Agency and Public Health Department, Mercy Medical Center Merced and Golden Valley Health Centers, HCAC members include Castle Family Health Center, Central California Legal Services, Community Action Agency, Department of Workforce Investment, Healthy House within a MATCH Coalition, First 5 Merced County, Livingston Medical Group, Memorial Hospital Los Baños, Merced College, Merced County Department of Mental Health, Merced County Housing Authority, Merced County Office of Education, Migrant Education, Head Start, WIC and Merced Lao Family Community.

[2] Amy J. Davidoff, Bowen Garrett, Matthew Schirmer. Children eligible for Medicaid but not enrolled: How Great a Policy Concern? No. A-41, “New Federalism: Issues and Options for States.” Urban Institute. September 1, 2000. http://www.urban.org.

[3] Stoddard et al. May 1994, New England Journal of Medicine.

[4] Children’s Health-Why Health Insurance Matters.

[5] Edmunds and Coye. *America’s Children.*

[6] Edmunds and Coye. *America’s Children.*

In September 2003, the Merced County Health Care Consortium (MCHCC), a collaborative of Golden Valley Health Centers, Mercy Medical Center Merced, Merced Faculty Associates (MFA), Merced County Human Services Agency, Merced County Department of Public Health, Livingston Medical Group, and Castle Family Health Center, was awarded a Healthy Communities Access Project (HCAP) grant from the federal Health Resources and Services Administration. The consortium was formed several years ago, when the County sold its hospital to Catholic Healthcare West, making it the sole hospital provider in Merced. A primary objective of the HCAP project is to increase access to public insurance in the county. In its first year, the HCAP project initiated an outreach, eligibility assistance and retention program to develop inter-agency coordination in each geographic area of the county among agencies that interact with uninsured, low-income residents to bring them into contact with primary care safety net providers, to provide assistance to enroll potentially eligible residents into public insurance programs and to help them retain coverage.

The MCHCC is a driving force in the movement toward a Merced Children's Health Initiative. With the participation of other vital and interested parties, it acts as the local CHI Coalition, with a Steering Committee created to guide the work of expanding children's health insurance. Its members include key leadership necessary for any real change in health coverage in the county and provide depth and breadth of experience, expertise and enthusiasm for the project. The Steering Committee, led by the Chairman of the Merced County Board of Supervisors, has combined the resources of advocacy groups, county departments and health care providers, and jointly have reached a consensus that uninsured children in the county would best be served by an integrated system for Medi-Cal, Healthy Families, expanded children's coverage and indigent care. A financial commitment from the First 5 Commission represented the first serious step toward financial backing. Then, support from both The California Endowment and California HealthCare Foundation (CHCF) have energized formation of this leadership group.

In September, 2004, the Merced County Children's Summit adopted the goal that "All children and youth will be healthy." The context for this goal was the finding that there is a crisis in health outcomes for residents in the San Joaquin Valley which is linked to poverty, poor air quality, a lack of health care providers and the lack of health insurance, among others. The Summit's action plan cited the absence of health insurance as one of the most important prerequisites for accessing health care, helping to ensure that children stay healthy by easing the road to early diagnosis and treatment of problems.

In October, 2004, the Merced County Department of Public Health, working with MCHCC, requested $49,179 from CHCF's Step by Step Initiative to hire a project coordinator, build a local coalition and local support and conduct a feasibility analysis to explore the potential of an insurance program for all children in Merced County with incomes below 300% Federal Poverty Level (FPL). The Merced County Department of Public Health plans to leverage funding from local, state and federal sources, such as First 5, AB 495 and foundations. This feasibility and planning study was designed to look at successful countywide programs already begun in several other California counties and help identify implementation strategies for a CHI in Merced County.

More specifically, this feasibility and planning study was intended to:

- Identify the target population of low income, uninsured children in Merced County;
- Describe experiences in other California counties that could be helpful to Merced County;
- Design and analyze health plan scenarios and prospective health plan carriers to provide a new children's insurance expansion product;
- Estimate health care premium costs for a children's health insurance expansion product; and
- Identify key financing and fundraising requirements, including potential funding sources; and
- Propose recommendations and next steps for local action.

New Developments In California To Insure Children

In a uniquely California response to reports of increasing numbers uninsured children, local coalitions have stepped up to the challenge of promoting the fullest use of existing public health insurance programs and expanding health coverage to other low-income children and families through campaigns called a Children's Health Initiative (CHI). The term was coined in Santa Clara County in 2001, for the concept of an intense, grassroots, countywide campaign to provide access to health coverage for uninsured children residing in the county whose family income is below 300% of the Federal Poverty Level. The strategy included promotion of enrollment in Medi-Cal, Health Families and for low-income children ineligible for those programs, a new health insurance product to fill the gap. Following the example of Santa Clara County, several California counties have developed their own versions of a CHI.

While the structure, financing and political dynamics have varied in each county with a CHI, the vision, target population and expansion insurance products have been similar in scope. The programs seek to reach all children living in families with incomes up to 300% FPL who do not qualify for existing public coverage such as Medi-Cal and Healthy Families. Through peer-to-peer support and external technical assistance, the CHI model has been pioneered in almost a dozen counties and is under development in at least twenty others. 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;
- Creating a single outreach and enrollment pathway; and
- Organizing a new children's insurance expansion product.

The local CHIs have created new coverage expansion programs called "Healthy Kids," which typically mirror the Healthy Families Program. Healthy Kids provides a comprehensive scope of benefits and affordable premiums and cost sharing for families who are not eligible for Medi-Cal or Healthy Families and whose family incomes are below 300% FPL. Most of the county children's coverage expansion programs partner with their local public Medi-Cal managed care plan (local initiative, county organized

health system) to administer at least the health plan portion of the Healthy Kids product, which serves as the designated health plan for Healthy Kids members. Counties without publicly-sponsored health plans are seeking participation from such plans in neighboring counties or from commercial plans.

Opportunities and Challenges in Merced County

With the seriousness of the challenges facing low-income children lacking health insurance, Merced County will want to accelerate action as soon as possible to ameliorate the problems. However, to be successful and prudent, it will have to temper the eagerness and in some respects, desperation, with the reality of acquiring the resources to achieve its objectives and a state policy environment that will certainly change over the next half dozen years.

In reviewing the challenges and opportunities presented today to Merced County, it is important to keep in mind some important questions that will influence decision-making going forward:

- How will the urgency and severity of the need for an expanded children's health insurance program influence the planning process? How can time be used best?
- How can the eventuality of Medi-Cal managed care be integrated with Healthy Kids and CHI, as it has in many other California counties?
- How can Merced County build the infrastructures required to operate a CHI and oversee a publicly-sponsored Medi-Cal managed care plan? What local resources can be used?
- What amount of funding must be raised to organize a CHI and develop a children's health insurance product and what restrictions might be placed on donated or granted funds?
- What measures will assure that the policies of the CHI effort will be responsive and accountable to the needs of Merced County?

What are the Scenarios for Insuring Low-income Children in Merced County?

What are possible ways for health care coverage to be provided to uninsured children in Merced County? This report describes five possible scenarios for linking an insurance program for uninsured low-income children not qualifying for Medi-Cal or Healthy Families with one or more health systems to deliver care. These scenarios are:

- Use CaliforniaKids (CalKids);
- Offer a Healthy Kids product through commercial health plans operating in Merced County;
- Offer a Health Kids product through a single commercial health plan and transfer Healthy Kids to a future Medi-Cal managed care plan;
- Purchase Healthy Kids through the proposed MRMIB Buy-In (e.g. Healthy Families Look-Alike); or

- Postpone implementing a new uninsured children's coverage until a Medi-Cal Managed care plan is developed for Merced County.

These options range from starting a limited and inexpensive Healthy Kids program as soon as possible to postponing a children's health insurance program until a more ideal system which incorporates Medi-Cal managed care and Healthy Kids, is organized.

Funding: *The California Experience and Issues Facing Merced County*

This report estimates that the health care premium costs, including health, dental and vision coverage, for all low income, uninsured children will be approximately $3,091,200 per year. Essential CHI financing components and strategies are: 1) securing planning and anchor funds; 2) securing local funds; 3) securing external funds; 4) program staging to match financing with enrollment levels; 5) adjusting to funder restrictions; 6) evaluating "fund holder" options; and 7) developing long-term sustainability. While all seven components are essential, only the first six are necessary for start-up. Remarkably, CHIs have assembled a varied group of funders. The actual variety of funders and amount of their respective contributions to the initiative are a result of each county's economic, demographic, political and organizational environment. With the extraordinary financial commitment of $480,000 for four years from First 5 Merced, local anchor funding has been secured for low income, uninsured children 0-5 years. Clearly, with this financial start, fund development for a children's health insurance expansion is underway.

Conclusions and Recommendations

Conclusions

- Too many children lack health insurance in Merced County. This recognition must strongly influence the need to establish a campaign to enroll children in existing public health coverage programs to develop a new health insurance product for low-income children who do not qualify for existing public programs.

- Merced County must continue the outreach, enrollment assistance and training activities currently performed by HCAP.

- Merced County cannot afford to lose the momentum built by the efforts of the First 5 Commission, the Board of Supervisors, HCAP, the CHI Steering Committee and the Children's Summit. This broad support can fashion measures to address the uninsured problem in Merced County now.

- Other California counties have organized successful initiatives to cover low-income uninsured children using intense outreach and enrollment campaigns while collaborating with local Medi-Cal managed care plans. To build on successful experiences elsewhere, Merced County must link its Children's Health Initiative with Medi-Cal managed care, because in the long run, public accountability has been a predictor of responsive operation and successful fundraising.

Recommendations

1. Continue the aggressive program of outreach and enrollment assistance in existing public health coverage programs to target eligible children who are eligible, but not enrolled in Medi-Cal or Healthy Families.

2. Bolster enrollment assistance efforts with education on appropriate use of health care services and enrollment retention to assure access and continuity of care.

3. Even as local planning for Medi-Cal managed care begins, contract with a commercial health plan or with CalKids to provide expanded coverage for low-income children not eligible for public insurance programs. Make it clear to the plan that this arrangement is not a precursor to Medi-Cal managed care in Merced County, but simply a "gap" approach to address the immediate problem.

Next Steps

Step One: Discuss this planning and feasibility report with the CHI Steering Committee and the CHI Coalition. Deliberate on conclusions and achieve agreement to move forward.

Step Two: Present this planning and feasibility report to the Merced County Board of Supervisors and to the First 5 Commission with the Steering Committee's recommendations for moving forward.

Step Three: Identify the administrative infrastructure needed to initiate a formal CHI organization, stabilize and sustain HCAP efforts, hire staff to coordinate CHI activities and serve as a link to HCAP and any other outreach and enrollment campaigns.

Step Four: Bring health care providers together for a briefing on CHI and Medi-Cal managed care. Use the opportunity to talk about the potential galvanizing power of a countywide effort in Merced County.

Step Five: Develop a Letter of Interest and release to health plans by October 1, 2005, with responses due by November 1, 2005, to gauge interest in providing a gap coverage product.

Step Six: Develop a fundraising plan and implement by November 1, 2005.

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1. Introduction

Serious and committed efforts to change the rate of uninsurance in Merced County have been underway for the past few years. In January 1999, the Health Care Access Coalition (HCAC) began mounting a concerted effort to enroll eligible individuals in Medi-Cal through a countywide Medi-Cal outreach program.

In September 2003, the Merced County Health Care Consortium (MCHCC), a collaborative of Golden Valley Health Centers, Mercy Medical Center Merced, Merced Faculty Associates (MFA), Merced County Human Services Agency, Merced County Department of Public Health (MCDPH), Livingston Medical Group, and Castle Family Health Center, was awarded a Healthy Communities Access Project (HCAP) grant from the federal Health Resources and Services Administration (HRSA). A primary objective of the HCAP project is to increase access to public insurance in the county. In its first year, the HCAP project initiated the outreach, eligibility assistance and retention (OEAR) program to develop inter-agency coordination in each geographic area of the county among agencies that interact with uninsured, low-income residents to bring them into contact with primary care safety net providers, to provide assistance to enroll potentially eligible residents into public insurance programs and to help them retain coverage. The successful OEAR program could be the foundation on which to build a larger initiative to arrange health care coverage for uninsured children.

In October, 2004, MCDPH, working with MCHCC, requested $49,179 from the California HealthCare Foundation's (CHCF) Step by Step Initiative to hire a project coordinator, build a local coalition and local support and conduct a feasibility analysis to explore the potential of an insurance program for all children in Merced County with incomes below 300% of the Federal Poverty Level (FPL). MCDPH plans to leverage funding from local, state and federal sources, such as First 5, AB 495 and foundations. The feasibility and planning analysis was designed to look at successful countywide programs already begun in several other California counties and help identify implementation strategies for a Children's Health Initiative in Merced County. The study will build on MCHCC's commitment to find a medical home for all residents.

More specifically, this feasibility and planning study was intended to:

- Identify the target population of low income, uninsured children in Merced County;

- Describe experiences in other California counties that could be helpful to Merced County;
- Design and analyze health plan scenarios and prospective health plan carriers to provide a new children's insurance expansion product;
- Estimate health care premium costs for a children's health insurance expansion product;
- Identify key financing and fundraising requirements, including potential funding sources; and
- Propose recommendations and next steps for local action.

Like all counties which have considered the development of a Children's Health Initiative, Merced County will face challenges common to all counties, as well as its own unique set of challenges.

The MCHCC is a driving force in the movement toward a Merced Children's Health Initiative. With the participation of other vital and interested parties, it serves as the local CHI Coalition, with a Steering Committee created to guide the work of expanding children's health insurance. Its members include key leadership necessary for any real change in health coverage in the county and provide depth and breadth of experience, expertise and enthusiasm for the project. The Steering Committee, led by the Chairman of the Merced County Board of Supervisors, has combined the resources of advocacy groups, county departments and health care providers, who jointly have reached a consensus that uninsured children in the county would best be served by an integrated system for Medi-Cal, Healthy Families, expanded children's coverage, indigent care and any other programs that provide or expand coverage or services for health care. Support from both The California Endowment (TCE) and CHCF has spurred formation of this leadership group.

HCAC's membership holds considerable overlap with MCHCC, and those not already involved have been invited to join the CHI Coalition, both the Steering Committee and working groups. The following agencies and groups are represented:

- Department of Public Health
- Human Services Agency
- Mercy Medical Center Merced
- Golden Valley Health Centers
- Castle Family Health Center
- Central California Legal Services
- Community Action Agency
- Department of Workforce Investment
- Healthy House within a MATCH Coalition
- First 5 Merced County
- Head Start
- Livingston Medical Group
- Memorial Hospital Los Baños
- Merced College
- Merced County Department of Mental Health
- Merced County Housing Authority
- Merced County Office of Education
- Merced Faculty Associates
- Merced Lao Family Community
- Migrant Education
- WIC.

The general goals and objectives of HCAC include: reduction in the number of uninsured and underinsured Merced County residents; access to health care services

based upon client needs; support programs that bring added services to the underserved members of Merced County, including specialty clinical services; support administrative efficiency; provide educational programs to HCAC members and their clients; encourage consumer input; and monitor and report on government-sponsored health coverage data for Merced. As a result of its ongoing meetings, there have been improvements to make the Medi-Cal enrollment process more efficient and effective and a helpline for providers who have questions about Medi-Cal eligibility has been initiated.

Local leadership has also come from the First 5 Commission Merced County which has committed $480,000 over four years to improve access to health care for children prenatal through age five years in Merced County. This commitment gives promise to the overall effort to secure sufficient funding to cover all uninsured children in Merced County.

Another example of local leadership in Merced County is demonstrated in the "Children's Action Plan." In September, 2004, the Merced County Children's Summit adopted the goal that "All children and youth will be healthy." The context for this goal was the finding that there is a crisis in health outcomes for residents in the San Joaquin Valley which is linked to poverty, poor air quality, and a lack of health care providers, and the lack of health insurance, among others. The Children's Action Plan cited health insurance as one of the most important prerequisites for accessing health care, helping to ensure that children stay healthy by easing the road to early diagnosis and treatment of problems. The report further observed that children who do not have health insurance are three times less likely to have a regular source of medical care, and as a result, less likely to receive routine primary care and specialist care. The Summit also adopted the objective that increased numbers of children and youth have access to health, dental and mental health care, as measured by the percentage children enrolled in insurance programs such as Medi-Cal and/or who have a medical home. Four action steps were incorporated into the Children's Action Plan to achieve this objective:

- Develop and implement a Children's Health Initiative, promoting health insurance and access to health care for all children in Merced County;
- Increase outreach for hard-to-reach populations, such as families in migrant camps and those living in extreme poverty, to improve access to health resources and services;
- Develop a culturally competent and appropriate "promotores" system ("cultural mediators") to assist health care providers with case management and/or wrap around services; and
- Develop and implement a public awareness campaign—multilingual and multicultural—about health and wellness.

2. Who are the Uninsured Children in Merced County?

A significant proportion of Merced County's residents have low family incomes according to both national and California data. For example, the Merced Statistical Metropolitan Service Area ("SMSA") is the third poorest in the nation. In 2003-2004, 65% of Merced County children enrolled in public schools received free or reduced price

school meals compared to 49% of children statewide. Consequently, Merced County could be expected to have high enrollment in the two largest public health insurance coverage programs, Medi-Cal and Healthy Families. Since, as it will be explained later in this report, income is a key predictor of health insurance coverage, in spite of enrollment in Medi-Cal and Healthy Families, it is likely that many low-income children are still uninsured.

Table 2-1 below summarizes the numbers of Merced County children enrolled in Medi-Cal and Healthy Families, as of December, 2004. There were 37,989 enrolled in Medi-Cal and 6,599 children enrolled in Healthy Families. About 44% of all Merced County children 0-17 years, were enrolled in Medi-Cal in 2002, compared to 30.5% of all children statewide. Merced County was third highest among the eight San Joaquin Valley counties. In the countywide age range 0-5 years, 51% of whom were enrolled in Medi-Cal, Merced County ranks above the state average (37.8%) and is in the mid-range among the San Joaquin Valley counties for this age category. The Healthy Families enrollment of children 0-18 years in Merced County (7.2%) exceeds the statewide average (6.4%), and also exceeds all San Joaquin Valley counties except Tulare County.

Table 2-1
Merced County
Enrollment of Children 0-18 Years in
Medi-Cal and Healthy Families
As of December, 2004

Public Program	Enrollment
Healthy Families	6,599
Medi-Cal	37,989
Total	44,588

Source: Healthy Families, CA Managed Risk Medical Insurance Board
Medi-Cal, CA Department of Health Services.

Since Medi-Cal and Healthy Families are restricted to children who are legal residents of the United States and whose family incomes are less than 250% FPL, enrollment in Medi-Cal and Healthy Families only tells part of the story. First, not all eligible children managed to enroll in Medi-Cal and Healthy Families, but all low-income children, as defined by 300% FPL (in 2005, $58,050 for a family of 4), may not even be eligible. (See Attachment III for *Federal Poverty Levels in 2005*.) In Table 2-2 below, using the results of the UCLA, California Health Interview Survey (CHIS), there are approximately 8,000 children in Merced County whose family income is below 300% FPL, but who are not insured. As a percent of all children in the county, Merced County's proportion of uninsured children (9.9%) exceeds the rates of uninsured children in the Central Valley (7.1%) and the state (7.0%).

Table 2-2
Merced County
Estimates of Uninsured, Ages 0-18 Years
2003

	Currently Uninsured			
	Below 300% FPL	**Above 300% FPL**	**ALL**	**Total 0-18 Years**
Merced County	8,000	2,000	10,000	81,000
Central Valley	84,000	10,000	94,000	1,179,000
California	699,000	79,000	778,000	10,051,000
Merced County	9.9%	2.5%	12.3%	100%
Central Valley	7.1%	0.8%	8.0%	100%
California	7.0%	0.8%	7.7%	100%

Source: AskCHIS, data query, California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, http: //www.chis.ucla.edu.

Based on the experience of other California counties, described in greater detail later in this Report, some of the uninsured children whose family income is below 300% FPL are eligible for Medi-Cal or Healthy Families, but have not enrolled. However, some low-income uninsured children are not eligible for either of those two public health insurance programs. Table 2-3 is a preliminary estimate of the likely eligibility of uninsured children for Medi-Cal or Healthy Families and the residual number of children who are ineligible for either. Based on statewide data obtained by the UCLA Center for Healthy Policy Research, and applied to Merced County, of the approximately 8,000 low-income children who are uninsured, approximately 1,920 are eligible for Medi-Cal and 3,280 are eligible for Healthy Families. An estimated 2,800 low-income children in Merced County are not eligible for either Medi-Cal or Health Families.

Table 2-3
Merced County
Preliminary Estimates of Uninsured Children,
Age 0-18 Years

Total Uninsured	10,000
Uninsured Below 300% FPL	8,000
Uninsured, Eligible for Medi-Cal	1,920
Uninsured, Eligible for Healthy Families	3,280
Uninsured, Ineligible for Public Programs	2,800

Source: AskCHIS Data Query of 2003, California Health Interview Survey, UCLA Center for Health Policy Research.
Note: CHIS 2001 % Uninsurance applied to 2003 CHIS data.

3. Public Health Insurance Coverage Programs and Pathways to Enrollment

This section covers two key areas: current public health insurance programs that provide coverage for low-income persons, including children, and special programs that have been developed to identify low-income children and provide an avenue to enroll them in these insurance programs. Public health insurance programs include: Medi-Cal, Healthy Families, CaliforniaKids and California Children‘s Services. Special programs to identify low-income children encompass such pathways as AB 495, Express Lane Eligibility and Child Health and Disability Prevention Gateway.

A. Public Health Insurance Programs

1. Medi-Cal

Medi-Cal is the state‘s Medicaid program, managed by the California Department of Health Services (DHS). It provides no-cost and low-cost health care coverage to low-income Californians. Approximately 52% of California‘s five million Medi-Cal beneficiaries are children under age 19. In California, State Children‘s Health Insurance Program (S-CHIP) funds are used to waive Medi-Cal's assets test for children and to supplement Medi-Cal "bridge" coverage for children transitioning from Medi-Cal to Healthy Families. States administer their own Medicaid programs following federal statutes and rules. Medicaid is an entitlement program, meaning that applicants who meet eligibility criteria will receive coverage.

Medi-Cal is available to pregnant women and infants with incomes up to 200% of the FPL (in 2005, $38,700 for a family of 4). Children ages 1 – 6 are eligible if their family incomes are 133% of FPL or lower. Parents and children 6 – 18 are eligible if their family incomes are below 100% of FPL. Qualified immigrants are eligible and this does not apply toward to issue of "public charge." Undocumented families are eligible for emergency or limited scope Medi-Cal benefits.

Medi-Cal benefits are comprehensive and include physician visits, hospital care, laboratory work, immunizations, prescriptions drugs, home health, contraceptives, hearing care, dental health and mental health.

2. Healthy Families

a. The Federal Program ("SCHIP")

The State Children's Health Insurance Plan ("SCHIP") was created in the Balanced Budget Act of 1997 (the BBA to help states expand health insurance coverage to children whose families earn too much income to qualify for Medicaid (Medi-Cal in California), yet not enough to afford private insurance coverage. States have had varying success in identifying and enrolling eligible children.

SCHIP is another federal program jointly funded by the federal government and the states. The federal share is higher for SCHIP than for Medi-Cal and states have greater flexibility in administering SCHIP than Medicaid. Unlike Medicaid, SCHIP is not an entitlement program: the federal government has budgeted a specific amount per year for the program through 2007. When either state or federal funding limits are reached, states may (and have) impose(d) waiting lists or enrollment freezes.

SCHIP offers states federal matching funds to expand health care coverage for children using Medicaid, a separate state children's health program, or a combination of the two. Reflecting the impact of SCHIP, census data reveal that the proportion of low-income children with publicly-funded coverage under Medicaid or SCHIP rose in 1999 and 2000 and that this resulted in a reduction in the percentage of low-income children who lack insurance coverage.

b. SCHIP in California: Healthy Families Program

California's SCHIP program, "Healthy Families," is a state- and federally-funded health coverage program for children with family incomes above the level eligible for no cost Medi-Cal and below 250% of the federal poverty line.[7] Healthy Families was implemented in California in July 1998 and is administered by the California Managed Risk Medical Insurance Board (MRMIB).

Healthy Families provides low-cost, comprehensive physical health, mental health, dental and vision coverage to uninsured children in low wage families. Like Medi-Cal, Healthy Families covers physician visits, hospital care, laboratory work, immunizations, prescription drugs, home health, contraceptives, hearing care, dental and mental health. Families participating in the program choose their health, dental and vision plan. Families must pay monthly premiums that are based on the selected health plan, the number of enrolled children in the family and family income. For example, premiums typically range from $4 to $15 per child, up to a maximum of $45 per month for 3 or more children in same family. Certain prescription drugs and physician visits also require a $5 copayment. Excluding vision and dental services, a family's annual total copayment may not exceed $250. Before enrollment in Healthy Families, a 90-day period without insurance is required of children who were previously enrolled in employer-sponsored health coverage, with certain limited exceptions. See Attachment I, *Comparison of Children's Coverage Programs' Summary of Benefits and Cost to Members*.

California law requires the Department of Health Services, in conjunction with MRMIB, to develop and conduct a community outreach and education campaign to help families learn about and apply for Medi-Cal and Healthy Families. The state's activities to increase enrollment in Medi-Cal and Healthy Families focused in two primary areas: 1) removing administrative barriers and 2) a community-based outreach campaign.

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[7] The federal poverty line is $19,350 for a family of four in 2005, as reported in the Federal Register for Department of Health and Human Services programs. aspe.hhs.gov/poverty/02poverty.htm.

California covers more previously uninsured children in its SCHIP program than any other state. In Merced County, Healthy Families currently contracts with two exclusive provider organizations (EPOs) and one health maintenance organization (HMO) for health services, as well as with separate plans for vision services and dental services. (See Table 3-1 below.) An EPO is similar to a traditional HMO and uses contracted network physicians, hospitals, ancillary healthcare providers and facilities. Neither the Blue Cross EPO nor the Blue Shield EPO requires the use of a Primary Care Physician (PCP), nor does the enrollee need a referral for a specialist in most cases.

Table 3-1
Merced County
Healthy Families Contracting Plans
July 1, 2005—June 30, 2008

Benefit Category	Contracting Plans
Health	Blue Cross EPO Blue Shield EPO HealthNet HMO
Vision	EyeMed Vision Safeguard Vision Vision Service Plan
Dental	Access Dental Delta Dental Western Dental

The Blue Cross EPO is the Healthy Families-designated "community provider plan" for Merced County which means that its health care provider network has the greatest proportion of providers who typically serve low-income persons than the other participating plans. This designation also means that Healthy Families enrollees pay a lower premium when joining the Blue Cross EPO.

c. Healthy Families Buy-In

It has been proposed that the Healthy Families Program develop a "buy-in" option that would allow enrollment in Healthy Families of uninsured children who are not otherwise eligible for Healthy Families with funding provided by local sources. MRMIB may develop this concept further in 2005. MRMIB's implementation of the buy-in concept would occur no sooner than July 1, 2006. This could provide a mechanism for insuring undocumented children through this state program. Under such a program, these new enrollees would select from among the participating health, vision and dental plans in the county of residence.

3. CaliforniaKids

CaliforniaKids Healthcare Foundation ("CalKids") was founded in 1992 with the mission to provide uninsured children access to basic health care services. CalKids is an independent non-profit organization that provides premium-subsidized, comprehensive

primary health care services to children ages 2 through 18. Currently, CalKids operates in several California counties, though it does not currently operate in Merced County. CalKids serves children whose family income is below 250% FPL, and largely because of immigration status, do not qualify for Medi-Cal or Healthy Families.

CalKids benefits include medical, dental, vision, prescription drugs, behavioral health and 24-hour nurse access. CalKids typically uses the Blue Cross EPO network for physicians' services and other large networks for its provider network. See Attachment I, *Comparison of Children's Coverage Programs-Summary of Benefits and Costs*.

CalKids assumes that uninsured children will make use of the public programs that are available to them – the California Children's Health and Disability Program (CHDP) – providing basic prevention services, the California Children's Services program (CCS) – for severely disabled children and emergency Medi-Cal – should hospitalization be required. The cost of non-covered services must either be paid for by families or borne by providers as uncompensated care.

CalKids partners with community organizations to identify and enroll eligible children. For example, partners include school nurses, Head Start and Healthy Start programs, child care councils, CHDP, Access for Infants and Mothers (AIM), Boys and Girls Club, Big Brothers, Big Sisters and community volunteers.

Importantly, CalKids is funded by donations, grants and monthly premiums from covered persons. A monthly premium payment of $15 per child is now required of participating families. Additionally, co-payments ranging from $5-$10 are required at the time services are rendered. The annual premium cost for CalKids is approximately $540.

4. California Children's Services ("CCS")

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Larger counties operate their own CCS programs. The program is funded with state, county and federal tax monies, along with some fees paid by parents.

If the parent or the child's doctor thinks that the child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if the child's condition is covered. If the child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help access special doctors and care for the child when medically necessary, and referral to other agencies, including public health nursing and regional centers.

- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

The CCS program is open to anyone who:
- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported as the adjusted gross income on the state tax form; or
- the out-of-pocket medical expenses for a child who qualifies are expected to be more than 20 percent of family income; or
- the child has Healthy Families coverage.

Family income is not a factor for children who:
- need diagnostic services to confirm a CCS-eligible medical condition; or
- were adopted with a known CCS-eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- are Medi-Cal beneficiaries, full scope, no share of cost; or
- are Healthy Families subscribers.

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical or rehabilitative services. There also may be certain criteria that determine if the child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and some examples of each:
- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care
- Disorders of the skin and subcutaneous tissue (severe hemangioma)
- Medically handicapping malocclusion (severely crooked teeth)

Families (or the applicant if age 18 or older, or an emancipated minor) must:
- complete an application form and return it to their county CCS office;

- give CCS all of the information requested so CCS can determine if the family qualifies;
- apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

B. Pathways to Enrollment in Public Health Insurance Programs

A number of avenues or pathways have been designed to identify and enroll low-income children in public health insurance programs.

1. AB 495

Assembly Bill 495 authorizes MRMIB to establish an innovative mechanism that allows county and local agencies to apply for federal SCHIP funds. Under AB 495, county agencies, local initiative and county organized health systems, can use local funds to draw federal SCHIP available money that would expand access to health care for potentially tens of thousands of children. Specifically, the legislation would allow counties to expand coverage from 200% of FPL, the maximum income currently allowed under Healthy Families, to 250% of FPL. The source of local matching funds will be closely scrutinized and cannot include any funds that may have originated from federal dollars (e.g., Medi-Cal, Medicare).

The state, under the lead of MRMIB, received approval of its State Plan Amendment (SPA) by the Federal Centers for Medicare and Medicaid Services (CMS) to permit Federal funding of children's health programs already operated by four counties: San Mateo, San Francisco, Alameda and Santa Clara. Once a contract is negotiated with these four pilot counties, they may begin drawing down a 65 percent federal match for health care coverage costs incurred on behalf of SCHIP eligible children between 250% and 300% FPL. A second SPA will be submitted in early 2005 for additional counties which are operating children's health initiatives, or will be in the process of implementing one by the date of the SPA's submission.

The requirements of AB 495 will create greater uniformity among gap coverage programs around the state than was originally contemplated when pioneer counties began to develop programs in 2000. Based on the SPA, to receive funding under AB 495, gap coverage programs will have to parallel the requirements with respect to benefits, quality assurance, cultural and linguistic standards, etc. that are expected under the Healthy Families Program.

While all potential funding is critical, the AB 495 program is at best only a partial funding source for Healthy Kids programs. First, SCHIP dollars are time-limited and set to expire in 2007. Second, children supported by these funds must have legal immigration status. Given that Healthy Kids programs have largely enrolled undocumented children below 250% FPL, these funds will support a small proportion of all children enrolling. Lastly, the federal application and reporting requirements are numerous and unless

documentation status information is collected according to CMS guidelines, the process may discourage some potential Healthy Kids applicants from applying for the program.

2. *Express Lane Eligibility*

In 2001, California enacted "Express Lane Eligibility" (ELE) legislation to open more doors through which the state's eligible, but uninsured children who are enrolled in the School Lunch and Food Stamps programs, can obtain Medi-Cal or Healthy Families. ELE was first implemented in 2003. The state already knows where many of these children are: the families of 80% of California's low-income uninsured children are enrolled in Food Stamps, WIC or the School Lunch Programs. There are 35,269 children enrolled in the School Lunch Program in Merced County (2003-2004).

ELE was built as an optional program for school districts that utilize the National School Lunch Program application. All County departments of social services (which determine Medi-Cal eligibility) in the state are required to participate. The following steps describe how ELE works:

- Step 1: A parent applies for Medi-Cal using the school lunch application. Parents within a participating school district apply for Medi-Cal coverage by authorizing the use of their child's school lunch application information for Medi-Cal purposes.

- Step 2: The school district reviews the school lunch application. Parents are notified of the school district's findings and all applications (whether eligible or not) are sent to the county within five working days,

- Step 3: An eligible child receives temporary benefits. Once a county receives the school lunch application from a school district, it checks to see if the child is already on Medi-Cal or Healthy Families. This coverage remains in place until a final Medi-Cal eligibility determination can be made.

- Step 4: The county sends an information request to the family for those not already receiving Medi-Cal. The form seeks the child's social security number and information on the child's immigration status and other health coverage, which Medi-Cal requires and school lunch does not. Although the child is not eligible for the temporary Medi-Cal coverage, he or she might still be eligible for full benefits under Medi-Cal, which allows certain deductions to income about which school lunch does not inquire.

- Step 5: The county makes a final Medi-Cal eligibility determination. A child not income-eligible for full Medi-Cal benefits will be sent a joint Medi-Cal/Healthy Families application. A child not eligible for full Medi-Cal benefits because of immigration status only will receive restricted Medi-Cal benefits.

ELE implementation began in 72 schools in five school districts located in the counties of Santa Clara, Fresno, Los Angeles, San Mateo and San Diego. Although ELE required budgetary authority to cover the cost of the Medi-Cal benefits of the children it would bring into the system ($3.5 million in state and federal funds were allocated in the 2003-04 budget year for this purpose), no implementation funds were allocated to school districts. Instead, California developed a public-private partnership through which foundation support would allow the state to test and fine-tune ELE on a relatively small scale.

The first year of ELE's implementation was successful in many ways. Based on early assessments, children are getting and using health insurance. Roughly half of all free-lunch children in the pilot school districts applied for health coverage under ELE. Of these, about one-third (or 2,000 children) received temporary Medi-Cal coverage. and in one pilot that number was as high as 50 percent. After subtracting the children who already had Medi-Cal or Healthy Families. Over 60 percent of children applying received temporary Medi-Cal coverage. The schools that implemented ELE represent less than one percent of all schools in California. Program administrators note, however, that the program has been successful in finding the hardest-to-reach children and making available health care coverage that families appear to use.

But, ELE also demonstrated the challenges inherent in integrating two public programs. The final enrollment numbers were lower than expected apparently due in part to parents not completing the second enrollment step. This may also be attributable to the fact that more children had health insurance than was originally estimated.

3. Child Health and Disability Prevention (CHDP) "Gateway" Program

The CHDP program provides free services to over two million low-income children and youth for the early detection and prevention of disease and disabilities. Half of the children served through CHDP are enrolled in Medi-Cal while half are uninsured. Most of these uninsured children are eligible for, but not enrolled in, Medi-Cal or Healthy Families. Children and youth receive, at no cost, periodic preventive health screenings. The same CHDP services are available for children who are not enrolled in Medi-Cal and who are under 19 years old with family income at or below 200% FPL.

DHS has developed an electronic "gateway" at CHDP provider offices and clinics that will link children with temporary Medi-Cal coverage. The CHDP Gateway program was implemented in 2003.

Children seeking CHDP services are electronically screened for eligibility. The Gateway process checks the Medi-Cal Eligibility Data System to determine if the child is already covered by Medi-Cal or Healthy Families. Each child under 19 years old with family income at or below 200% FPL who is seeking services from a CHDP provider is "presumed eligible" for Medi-Cal or Healthy Families on a temporary basis. Like the current CHDP program, there are no immigration requirements for this temporary Medi-Cal benefit period. However, children already enrolled in Medi-Cal with limited scope benefits because of unsatisfactory immigration status are not eligible for the temporary

full-scope coverage. If eligible, the child receives CHDP services and leaves the provider's office with temporary Medi-Cal health insurance coverage for a full scope of benefits. Families are given the option to apply for continuing coverage and must send in a full application to continue coverage beyond the 60-day temporary period.

4. Why are Children Uninsured?

From research and experience in other states and other California counties, including Merced and its neighboring counties, there emerge a number of reasons to explain why children in Merced County may not have health insurance. These reasons include:

- Children are not enrolled in public insurance programs for which they are eligible;
- Children may not be eligible for public insurance programs; and
- Private insurance is available, but is too expensive or limited in scope

A. Children are not Enrolled in Public Insurance Programs for which They are Eligible

Based on statewide data, of the estimated 8,000 low-income uninsured children living in Merced County, 65%, or about 5,200 children, are eligible for public health insurance but have not signed up, for a variety of reasons, including:

1. *Lack of knowledge* – many families do not know their children are eligible. Of the 355,000 uninsured children eligible for Medi-Cal statewide, parents of a third of the children interviewed for the California Health Interview Study (CHIS) conducted by UCLA's Center on Health Policy Research, thought that their children were not eligible. Another 8% reported being unsure about their children's eligibility as the reason for not applying and less than 1% did not know the program existed. This suggests that more than 40% of uninsured, eligible children could be reached by effective, culturally appropriate educational outreach strategies. Families eligible for Healthy Families had similar reasons for not applying, but the proportion of those who need effective education about the program is significantly higher than the Medi-Cal program (60% among Healthy Families eligible families compared to 42% of Medi-Cal eligible families). Nearly one quarter of parents of Healthy Families-eligible children did not know the program existed, nearly 20% believed their children were not eligible and an additional 14% did not know if their children were eligible. A study published in 2003, by Mathematica Policy Research, Inc., under sponsorship of the David and Lucile Packard Foundation, supported CHIS findings.

2. *Confusion with complex and differing enrollment requirements* and strict criteria to maintain coverage and administrative hassle. Parents of 12% of the children in CHIS objected to some part of the program, particularly the heavy burden of paperwork that has been a hallmark of Medi-Cal. This can be an obstacle to enrollment when parents choose not to enroll children because of the perceived administrative difficulties related to the enrollment process.

3. *Program fragmentation* results in a system in which children in the same family may be eligible for different health insurance programs because of immigration status. Under current eligibility rules, children who are citizens or noncitizens with legal documentation to live in the United States are eligible for either Medi-Cal or Healthy Families, if their family income is 250% FPL or below. In some families, some children were born in the United States while others have been born abroad. Conceivably, the family could have an older child not eligible for any public programs, a middle child eligible for Medi-Cal, and a younger child, also ineligible, having been born abroad. The specific program for which they are eligible depends on a complicated variety of factors, including their age, family income, allowed deductions from income and family size.

4. *Immigration issues and linguistic and cultural barriers* can lead to fear. Recent studies have found that low-income immigrants who speak Spanish as their primary language are less likely to have insurance coverage for their children or themselves than similar noncitizen immigrants who speak English. Language and cultural barriers make it challenging to parents to learn about public insurance programs, complete applications or obtain employment that provides health coverage. Parents may also be illiterate in their native languages.

5. *Ignorance regarding the need for insurance*. Though estimates have varied widely, some parents do not enquire or apply for coverage for their children because they do not want it or feel they need it.

6. *System flaws impair access*. The complex and often confusing eligibility, enrollment and renewal processes cause many children to lose coverage through no fault of their own. For example, a family who misses a premium deadline for Healthy Families is not allowed to reenroll for a specified number of months. The same family may be eligible for other partial coverage programs, with different copayments, deadlines, requirements for participation and health care providers. According to national reports involving several communities, "for every three children newly enrolled in SCHIP (Healthy Families in California), one drops out."

B. Children May Not Be Eligible for Public Insurance Programs

Approximately 35% of low-income uninsured children (2,800 children) in Merced County are not eligible for public health insurance, such as Medi-Cal and Healthy Families. Some proportion of that number may be ineligible due to income or to immigration status.

C. Insurance Available, but too Expensive or Limited in Scope

For many families, even some middle-income families, employer health insurance premiums may be too high for the family budget to bear. Health plan benefits and costs vary greatly from employer to employer. The amount that is covered by the employer and the portion that must be paid by the employee differs, as does the scope of services covered by each plan. In most cases, buying into an employer's group plan is usually less expensive than buying an individual plan. Studies show that when families have to spend higher proportions of their incomes to pay for health insurance, they are less

likely to pay for it. Without public subsidies or employer-provided health plans, families with incomes near poverty levels would have to pay a prohibitive 40 percent of their income for family coverage.

The cost sharing aspects or limits on benefits affect the usefulness of a health plan. Some plans do not extend coverage to spouses and dependents, or necessitate that the employee pay a significant cost to add dependents. Insurance plans may have deductibles that require users to pay anywhere from $100 to over $500 before services are covered. Families also encounter copayments for provider visits and lab work. Some plans do not cover certain services, such as prescriptions or dental care. These gaps in service require the outlay of cash, which many families cannot afford. Researchers estimate that about a fifth of insured individuals are under-insured due to these types of coverage limitations.

Whether or not an employer offers health insurance is influenced by industry standards and the size of the business. Compared to other states in the nation, California businesses have among the lowest rates of offering health insurance. Conversely, the state has one of the highest rates of employees accepting offered insurance, which shows employee desire to have coverage.[8] In Merced County's economy, the sectors which figure prominently – retail, service and agriculture – are also the sectors with the poorest history of offering insurance.

5. Health Insurance and Access to Care Are Important

Children's access to health care is important to children themselves, to their families and to the community. Health care can influence children's physical and emotional health, growth and development and their capacity to reach their full potential as adults. All children are at increased risk of developing preventable conditions if appropriate care is not provided when they are sick or injured. When children fail to receive necessary health care, their lives and the lives of their families can be affected for many years. There are a number of outcomes attributed to lack of insurance, outcomes affecting the individual children, the family and the community:

A. Effects on Individual Children

Usual Source of Care – Access to health care can influence children's physical and emotional growth, development and overall health and well-being. Untreated illnesses and injuries can have long-term—even lifelong—consequences. For example, untreated ear infections can lead to hearing loss or deafness. Children who are unable to hear well can have trouble performing well in school and have trouble interacting normally with their families and friends. Language or other developmental delays due to untreated neurological problems also can frustrate normal development and social interactions.[9] Overall, lack of insurance undermines children's health and damages their chances to lead a healthy life.

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[8] 2001 California Health Interview Survey, www.healthpolicy.ucla.edu. (CHIS)

[9] John Holahan, Ph.D., Lisa Dubay, M.Sc. and Genevieve Kenney, Ph.D. Which children are still uninsured and why. The Future of Children, Vol. 13:1, Spring 2003.

Dental care is a serious issue for uninsured families. Oral diseases affect not only the teeth, gums and the rest of the mouth, but they also can lead to serious general health problems and significant pain, interference with eating, overuse of emergency rooms, as well as lost school and work time. Preventive methods such as the use of fluoride and dental sealant are comparable in effectiveness to immunizations against infectious disease, but these services are not always readily available.[10]

Access to health care services dramatically improves within 12 months of health insurance enrollment. A study by the Urban Institute showed that at 12 months, 99% of the children had a regular source of care and 85% had a regular dentist. Research finds that uninsured children are six times more likely than insured children to lack a usual site of care (24% vs. 4%) and far less likely than insured children to have seen a physician in the past year. Further, when uninsured children have a usual place to go to for care, a quarter still lack a regular provider at that site.[11] Studies show that uninsured children, surrounded by the most expansive and expensive health system in the world, frequently cannot find their way to the care they need. Compared to insured children, uninsured children receive only limited access to health services.[12]

Delaying and Postponing Care Due to Costs – Based on national studies, 21% of parents of uninsured children compared to 3% of parents of insured children were forced to delay or skip needed medical care for their child because they did not know how to pay for it.[13] Twenty seven percent of parents of uninsured children compared to 7% of parents of insured children were forced to delay or skip needed dental care for their child during the past year because they did not know how they would pay for it.[14] Parents of uninsured children are seven times as likely as parents with insured children to have delayed or skipped filling prescriptions for their child.[15] Uninsured children are less likely than those with insurance to receive medical care for injuries, even serious injuries. Among children who are uninsured, one study found that as many as 30% of all children with injuries and 40% of all children with serious injuries may not receive medical attention.[16]

Disruption to the Continuity of Care – Continuous insurance coverage is an important determinant of continuity in health care. Among the nearly 36% of uninsured children who had insurance at some point of the year, such changes can disrupt ongoing services and cause the child to switch providers. Five times as many children with

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[10] Lessard, G. and Ku, L. Gaps in coverage for children in immigrant families. *The Future of Children.* Spring 2003.

[11] "Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?", Urban Institute No. B-35 May 2001 http://newfederalism.urban.org.

[12] Healthcare Access, California Journal, July 2002, Maria La Ganga.

[13] Wirthlin Worldwide Survey of American Families: Comparison of Household with insured children vs. uninsured children eligible for SCHIP/Medicaid Coverage. June 5-26, 2001.

[14] Wirthlin Worldwide Survey of American Families: Comparison of Household with insured children vs. uninsured children eligible for SCHIP/Medicaid Coverage. June 5-26, 2001.

[15] Wirthlin. *Survey*.

[16] Margaret Edmunds and Molly Joel Coye, Editors. *America's Children: Health Insurance and Access to Care.* Institute of Medicine. 1997.

incomes under 100% of FPL as those with incomes 300% of FPL are not covered nor had any gap in coverage in the past year.[17]

Poor School Performance – An impetus for the drive for enrolling as many children as possible into health insurance programs is the link between health insurance and school performance. According to *The Link Between School Performance and Health Insurance: Current Research, from the Consumers Union*, good health is connected with improved school performance and having health insurance is linked to better health. Poor health has been found to affect school performance in many ways, including contributing to absenteeism, affecting concentration level in the classroom, producing disruptive behavior and affecting students' abilities to participate in extracurricular activities.

Parents relate a significant decrease in stress, which has important implications for education because the well-being of the entire family can be critical to a child's readiness to learn.

Unmet Health Care Needs – The direct consequences of having less access to care are poorer health outcomes. Uninsured children are at least 70% more likely than insured children to not receive medical care for such common childhood illnesses as sore throats, ear infections and asthma. These conditions may have serious and irreversible consequences if left untreated. Uninsured children who are injured are 30% less likely than insured children to receive medical treatment.[18] The percentage of children reporting any unmet need or delayed care in the past six months decreased with enrollment into insurance.

- Uninsured children are almost three times as likely as insured children to have an unmet health care need within the past year.[19]
- Uninsured children are approximately twice as likely as insured children to not receive care from a physician for acute earaches, recurrent ear infections, asthma, or sore throat with a high fever.[20] These can lead to hearing loss, central auditory processing disorder and life-threatening emergencies.
- Uninsured children are 30% less likely than insured children to have received medical care when they are injured.[21]
- Children living in low-income areas have two to four times as many preventable hospitalizations as children living in high-income areas. These rates are likely to be due to poorer general health status, poorer access to

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[17] Inkelas, et.al. The Health of Young Children in California: Findings from the 2001 California Health Interview Survey. UCLA Center for Health Policy Research. July 2003.

[18] Children's Health-Why Health Insurance Matters, Kaiser Commission on Medicaid and the Uninsured, May 2002, www.kff.org.

[19] Amy J. Davidoff, Bowen Garrett, Matthew Schirmer. Children eligible for Medicaid but not enrolled: How Great a Policy Concern? No. A-41, "New Federalism: Issues and Options for States." Urban Institute. September 1, 2000. http://www.urban.org.

[20] Stoddard et al. May 1994, New England Journal of Medicine.

[21] Children's Health-Why Health Insurance Matters.

preventive and routine care when needed, as well as to lack of insurance among low-income families.[22]

- Uninsured children with chronic medical conditions have been found to have insufficient access to routine medical care. According to a national survey sponsored by the Robert Wood Johnson Foundation, 17% of uninsured children did not receive medical treatment needed for chronic illness such as asthma, diabetes or other conditions serious enough to keep a child from functioning at school.[23]

Unmet Preventive Care – Having insurance improves children's access to routine well-child care, which is important for children's health. This continuity allows better monitoring of children's development, when potential problems can be detected earlier at a time they are more responsive to treatment. It also fosters early intervention, which leads to improved health outcomes for children with treatable conditions such as ear infections and iron deficiency anemia. It also leads to better health outcomes for children with serious illnesses and disabilities.

- Uninsured are five times more likely to use the emergency room as a regular source of care.[24]
- In California, 68% of uninsured children compared to approximately 30% of insured children did not have a well-child doctor visit in the last year.
- Uninsured children between ages 1 and 3 are approximately twice less likely as insured children to have up-to-date immunizations.
- In California, 56% of uninsured children compared to approximately 25% of insured children did not have a doctor visit in the last year.
- In California, 55% of uninsured children compared to approximately 20% of insured children did not have a dental visit in the last year, or 2.5 times less likely to receive dental care.

B. Effects on the Family

Uninsured families are selective in their use of health services. Many wait until a crisis occurs. Delaying or forgoing treatment or preventive care can adversely affect health, even while it reduces costs in the short term. Twenty percent of parents of uninsured children ages 5-18 compared to 3% of parents with insurance between the same ages have kept or would keep their child out of a sporting of athletic event because of fear that they might get injured and have no way of being covered.[25]

While having insurance is one of many factors affecting health (along with genetics, poverty, diet, exercise, smoking and other behavioral factors), it is an important one. Uninsured children fare worse than insured children, even after taking into account

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22 Edmunds and Coye. *America's Children.*
23 Edmunds and Coye. *America's Children.*
24 Davidoff, et.al.. *Children eligible for Medicaid.*
25 Wirthlin. Survey.

family income, race/ethnicity and health status. While race, poverty and immigrant status are all associated with lack of insurance, research shows that each factor acts independently as a predictor of children's access to medical care. Of all of these factors, health insurance coverage is the most easily changed and the provision of coverage can improve health.[26]

If one member of a family has a serious health problem, such as a major trauma from a car accident or cancer, the resulting medical bills can destroy the economic stability of the entire family. Out-of-pocket medical expenses can be substantial for uninsured low-income families. One of four of these families has medical expenses that are greater than 5% of their small income. Since insurers, including Medicare and Medicaid, negotiate large discounts with hospitals and physicians, providers often offset by raising the costs to uninsured individuals such as children. [27] While living in poverty, uninsured families pay more than 40% of their medical costs by themselves.[28] At the same time, families risk bankruptcy: medical bills are a factor in nearly half of all personal bankruptcy filings.[29]

C. Effects on the Community

Strain on the Health Care System – Providers are less willing to see patients who have Medi-Cal coverage because of its low reimbursement rates—and even fewer who are willing to see patients who have no insurance at all. Taxpayers and providers bear the burden of financing care to the uninsured. County officials have observed that often times because of bureaucratic hassles, many health services are provided to the insured with the provider bearing the burden of uncompensated care from low or no reimbursement. This places a strain on the willingness of providers to accept beneficiaries of public health insurance programs. Compared to statewide averages, Merced County already has a scarcity of health care professionals.

Emergency Rooms are Overcrowded and Understaffed – Uninsured children are five times more likely than insured children to use the emergency room as a regular source of care. Research in other states has reported that when parents were helped to buy coverage for uninsured children, children received health care in doctors' officers rather than emergency departments. This saved providers, taxpayers and consumers millions of dollars.

6. New Developments in California to Insure Children

A. Children's Health Initiative and Healthy Kids

Over the past six years, in a uniquely California response to studies of increasing uninsured children, over the past five or six years, local coalitions have stepped up to

[26] Institute of Medicine (IOM). Health Insurance is a Family Matter. September 2002. www.iom.edu/uninsured.
[27] Wileawski, Irene. "Gouging the medically uninsured: a tale of two bills." Health Affairs, September/October 2000. Vol. 19, No. 5 pp. 180-185.
[28] IOM. Health Insurance is a Family Matter.
[29] IOM. Health Insurance is a Family Matter.

the challenge of promoting the fullest use of existing public health insurance programs and expanding health coverage to other low-income children and families through campaigns called the Children's Health Initiative (CHI). The term, CHI, was coined in Santa Clara County in 2000, for the concept of a grassroots, countywide campaign to provide access to health coverage for uninsured children residing in the county whose family income is below 300% of the FPL. The strategy included promotion of enrollment in Medi-Cal and Health Families and, for low-income children ineligible for those programs, a new health insurance product to fill the gap. Following the example of Santa Clara County, several California counties have developed their own versions of a CHI.

While the structure, financing and political dynamics have varied in each CHI county, the vision, target population and expansion insurance products have been similar. The programs seek to reach all children living in families with incomes up to 300% FPL who do not qualify for Medi-Cal or Healthy Families. See Table 6-1 below.

Table 6-1
Qualification for Public Health Insurance Programs By Age and Percentage of Federal Poverty Level

Age	Income Limit as % of Federal Poverty Level	Program Eligibility
< 1 year	At or below 200% 200-250% 0-300%	Medi-Cal Healthy Families Healthy Kids (gap)*
1-5 years	At or below 133% 133-250% 0-300%	Medi-Cal Healthy Families Healthy Kids (gap)*
6-18 years	At or below 100% 100-250% 0-300%	Medi-Cal Healthy Families Healthy Kids (gap)*

* Children ineligible for Medi-Cal and Healthy Families are eligible for Healthy Kids up to 300% of FPL

Through peer-to-peer support and external technical assistance, the CHI model has been pioneered in almost a dozen counties and is under development in at least twenty others. Attachment II describes the characteristics of selected children's coverage expansion programs in the state. 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,
- Creating a single outreach and enrollment pathway, and
- Organizing a new children's insurance expansion product.

The CHI model has influenced the policies and practices of county social and human services agencies. Where once these agencies 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 entry point, sometimes referred to as "One Open Door," for enrolling and retaining children in health care coverage. County staff and community-based assistors have been cross-trained to enroll families in *all* available public programs. In some counties, the single entry approach has been enhanced by a universal web-based application called One-e-App. 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. However, this electronic interface, while a promising technology, is not an essential tool.

The county CHIs have created new coverage expansion product called "Healthy Kids," which typically mirrors the Healthy Families Program in key respects. Healthy Kids provides a comprehensive scope of benefits, including health, vision and dental (see Attachment I) 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 family incomes are below 300% FPL. Each of the operational CHIs have partnered with one local public Medi-Cal managed care plan (local initiative, county organized health system, or commercial Medi-Cal plan) to administer at least the health plan benefit portion of the Healthy Kids product, which serves as the designated health plan for Healthy Kids members. Counties without publicly-sponsored health plans are seeking participation from such plans in neighboring counties or are contracting with commercial health plans. Under the still vague terms of a Healthy Families "buy-in," counties without publicly-sponsored health plans may have the option of using plans which currently participate in the Healthy Families program in the county and requesting MRMIB to administer their program locally.

7. Lessons Learned from Other California Counties

A. Healthy Kids Program Design and Policy Decisions

1. Eligibility

Healthy Kids programs typically cover children and youth ages 0-18 years 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.

2. Family Premiums and Other Cost-Sharing

Families are required to 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(ren) receive services. CHI leaders may consider establishing cost-sharing levels based on a family's gross monthly income as in other public insurance programs. Some counties have chosen to charge a family contribution equal to the level charged in the Healthy Families program. 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. Copayments generally follow the level used in the Healthy Families, such as $5 per visit or prescription.

Payment plans can 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 encourage families' participation and ensure 12 months of continuous coverage. The CHIs in the counties of Santa Clara, San Mateo and San Francisco have policies in place that provide three months of free coverage if the family pays the entire 12 months of coverage upon enrollment.

3. Annual Eligibility Renewal

Another significant program policy involves the process for eligibility redetermination at the end of the current 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 successful renewal coverage at the annual eligibility determination is known as "retention." 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.

4. Hardship Funds

Many CHIs 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. There, the 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 the duration of enrollment period.

5. Waiting Lists

Around the state, county First 5 Commissions have generally provided funding to cover the cost of Healthy Kids premiums for eligible children 0-5 years. CHIs must look to other funders to cover a much larger number of uninsured children in the 6-18 year old age category. The difficulties faced in securing funding for older children has resulted in four of the operational CHIs to implement policies that create waiting lists for eligible children ages 6-18 years in their Healthy Kids programs due to insufficient funding. Newly emerging CHIs also have to consider policies in the event they encounter difficulty in securing adequate funding at the very beginning to launch their Healthy Kids programs for all eligible children 0-18 years.

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 designated level of enrollment and as children leave the program, new children are enrolled to take their places. All CHIs with enrollment caps in place have created waiting lists. Enrollment freezes suspend enrollment after a certain date. Enrollment is not reopened until a sufficient number of children leave the program and a designated enrollment threshold floor is reached.

As of May 2004, four counties have established waiting lists in their Healthy Kids program. The high demand for Healthy Kids 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 years. In almost all of the counties, funding for all children 0-5 has been available through 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 may be required to put their children 6 years of age or older on the waiting list for the same insurance program.

6. Coordination with Other Programs

Most established Healthy Kids insurance products have been able to “carve out” California Children’s Services (CCS) coverage. Like Healthy Families, Healthy Kids have been able to transfer financial and treatment responsibility for CCS conditions to the CCS program once a child has been determined CCS-eligible and if family income is less than 250% FPL. 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.

7. Minimizing "Crowd Out"

The term "crowd out" refers to the phenomenon in which the availability of publicly-subsidized insurance is used in place of enrollment in existing employer-sponsored coverage; hence, free or low-cost public coverage "crowds out" more costly 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 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:

a. *Sliding scale premium contributions:* 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 set at a level that deters them from declining dependent coverage from their employers.

b. *"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. 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 an employer contribution option, where employers and employees share the premium costs.

B. Outreach, Enrollment and Retention

Outreach informs community members about available programs and other social services and is the starting point for CHI success. Outreach workers, who are also

referred to as community health advisors, family support workers and in some cases Certified Application Assistors (CAAs), are the frontline messengers to communities about the availability of insurance for kids through the Healthy Kids, Medi-Cal and Healthy Families programs.

Through its Healthy Communities Access Program (HCAP), Merced County has been developing its own local outreach, enrollment and retention infrastructure. Sponsored by the federal Health Resources and Services Administration's Bureau of Primary Health Care, HCAP is a consortium of public and private healthcare providers – as well as social service, local government and other community-based organizations – working together to coordinate and strengthen health services for the uninsured and underinsured in their communities. HCAP has been made possible by grants received by the Merced County Health Care Consortium since 2003.

HCAP performs several activities to realize its goals. The first activity area is an Outreach, Eligibility Assistance and Retention (OEAR) component to identify low-income, uninsured and underinsured residents of Merced County. HCAP encourages them to enroll in public insurance programs for which they may be eligible, encourage and reinforce low-income residents (with or without insurance) to link up with primary care safety net providers so that they can establish medical "homes" for themselves and their family members and support them in retaining health insurance coverage.

To accomplish its OEAR objectives, HCAP also hires, trains and deploys outreach assistance workers (e.g. Certified Application Assistors (CAAs) to enroll persons into the Medicaid, Healthy Families and CHDP programs. HCAP's deployment plan now includes 14 regular service site locations, as well as many special outreach events and community presentations each month. Schools and other community organizations are expected to be the focus of non-clinical provider deployment site activity. All initial sites are high volume ambulatory health care facilities where a high percentage (20-40%) of the clients are uninsured. For example, in the past year, HCAP hired and trained nine bilingual English/Spanish/Hmong CAAs and stationed them at community clinics and school sites with large percentages of children who receive free or reduced price lunches. According to HCAP, for the period July, 2004-June, 2005, CAAs completed 7,953 health coverage applications of which 4,356 or 54.8% were for children 0-18 years of age. Deployment at the major hospital emergency department in the county has not been successful both for logistical and regulatory reasons.

As residents are successfully enrolled, they will be given additional assistance in identifying and establishing first contact with a health safety net provider. Residents who are unable to enroll successfully in an insurance program will still receive assistance in making contact with a health safety net provider. They will be referred to an appropriate safety net provider.

HCAP's other outreach activities include participation in 61 major community events and presentations through April 30, 2005. A radio campaign and a number of onsite informational events were mounted in conjunction with the national 'Cover The Uninsured Week' campaign. While important presentations have been made at the

largest local shopping mall and to faith-based organizational leadership and congregations, their yield of referrals that result in a health coverage application is less than an established deployment site serving a high percentage of the uninsured.

To achieve another of its goals, HCAP is establishing a follow-up retention plan for those enrollees first enrolled through the direct efforts of HCAP—estimated at only 8% of all Medi-Cal beneficiaries. For this group, HCAP has good data. However, no simple local program and automated system has been developed that could utilize existing renewal databases.

Another set of activities to achieve its goals includes the formation and practice of HCAP's "integrated care" component with the participation of all safety net providers. HCAP's Office of Integrated Care, consisting of this Work Group and HCAP staff, will addresses key areas such as the following:

- A single, uniform registration form for all health safety net providers.
- For insurance eligible residents, a single, uniform supplement to the registration form for use in developing and submitting insurance applications.
- A set of patient education materials with linguistic and cultural variations, explaining the safety net options in Merced County, and how patients can benefit from establishing a relationship with a primary care provider.
- A policy statement for patients regarding their rights and restrictions in terms of accessing various health care safety net providers, including appropriate use of emergency services.
- A Merced County safety net directory of primary care providers available to patients, including the linguistic and cultural capabilities of the provider.

Lastly, a new and improved health coverage assistance and safety net provider-listing brochure is being developed. It will be published in four languages (English, Spanish, Hmong & Punjabi) was scheduled for distribution in June 2005. The distribution plan includes all provider offices, county agencies, social service agencies, retail stores, pharmacies, school nurses, laundromats, flea markets and neighborhood grocery stores.

In reflecting on how to achieve its health-related goals and objectives through workable strategies, the Merced County Children's Summit, cited earlier in this report, observed that intensive enrollment outreach is important for assisting families to access Medi-Cal and Healthy Families programs for their uninsured children. Enrollment sites can be located in neighborhoods using bilingual and bicultural staff to educate parents about what is available and to address their concerns that enrollment may have a negative impact on their immigration status. It is important to have multiple access points for preventive routine care for low-income children and families and to offer services in the evening and on weekends for families who cannot get off work to take their child to the doctor. School nurses and school-based or school-linked clinics are helpful in identifying and addressing problems early. It is sometimes necessary to provide transportation. Services must be linguistically appropriate and culturally sensitive. Interpretation by trained interpreters is effective in helping the patient and doctor understand each other.

It is also essential to build communication and understanding between western medical providers and traditional practitioners.

Several CHIs have adopted a single entry point concept of outreach and enrollment activities to simplify family access to the full range of available health and other social service programs, including Healthy Kids. In these counties, a single entry point concept has prompted a thoughtful reorganization and streamlining of existing outreach, enrollment and retention efforts across county health and social service agencies, as well as community organizations. A coordinated outreach and enrollment assistance model allows families to receive specialized application assistance for separate programs through a single contact at a variety of social service venues and community settings rather than working through a confusing and time-consuming complex of programs and redundant processes.

1. Outreach Planning

Once a county has committed to streamlining outreach and enrollment, it can begin to map out its strategies for doing so as several other counties have done.

Target Population Identification -- Pressure to maximize limited outreach funding may force CHIs to make choices about what populations to target and how extensive an outreach strategy to pursue. Knowing the demographics of target outreach populations in the community, particularly child coverage gaps by family income level and ethnicity, is critical in stretching outreach funds to maximum effectiveness.

In general, CHI outreach and enrollment strategies focus on two distinct populations:

- Children eligible for but not enrolled in Medi-Cal or Healthy Families; and
- Children ineligible for public programs without access to affordable private insurance, including children without legal immigration status and children from families with income at or above 250% FPL.

Though appearing distinct, these two populations are not separate. Many of the children who are eligible for Medi-Cal and Healthy Families but not enrolled are the siblings of children who are ineligible for those programs due, in large part, to their immigration status. Coordinated outreach strategies for Healthy Families, Medi-Cal and Healthy Kids should be particularly effective in capturing many of these previously uninsured eligible children. In these mixed status families, parents are more likely to follow through on enrolling eligible children in Medi-Cal and Healthy Families since their ineligible children are able to apply to the Healthy Kids program. However, even a carefully coordinated outreach approach for these families will only be effective if conducted in a culturally appropriate manner, using known and trusted sources and organizations such as community health centers, family resource centers, schools and migrant education programs.

Family income level is another major consideration in creating effective outreach and enrollment messages and approaches since family income level is highly correlated with access to private insurance coverage. Families with annual incomes above 250% of the federal poverty level generally are more likely to have been privately insured at some time and more familiar and comfortable with commercial health insurance marketing. Outreach to this higher income population may require more mainstream publicity generating activities, working with insurance brokers and employers directly, and a more extensive marketing budget.

Inventory of Existing Outreach Activities – Most CHIs have chosen to invite representatives from all entities planning or operating outreach activities for Medi-Cal and Healthy Families as well as other public programs to an orientation on the purpose of the CHI and to introduce the Healthy Kids program. These meetings generally have included directors of the health and social services agencies, community clinic directors, public hospital community outreach managers and representatives of the school districts as well as any other community-based organizations (CBOs) involved with outreach, such as labor and faith-based organizations.

Outreach Collaboration in San Mateo County – San Mateo initiated its Healthy Kids outreach planning by inviting all stakeholders to a kick-off meeting, including the Health Services Agency, Human Services Agency, county contractors, all school districts in the county, the county's legal aid society, labor representatives and others. Since that initial meeting, all participants have contributed to the Healthy Kids program's outreach success: legal aid agencies helped craft messages on the public charge issue that could be distributed to the community; labor organizations held outreach fairs and documented the experiences of the uninsured that the CHI has used in its outreach and marketing efforts; school districts and CBOs have formed partnerships to more efficiently enroll families identified through the Request for Information sheets sent out by the schools; and county contractors have worked together to identify specific target populations and the best strategies to reach these populations.

2. Outreach Strategies

The major strategies used to expand health coverage to uninsured children and families are in-reach, general community outreach and school-based outreach. This section provides a brief overview of these strategies and specific ways in which CHIs have deployed them.

In-Reach and Joint-Outstationing Activities – In-reach activities identify and enroll into public programs children whose families are seeking services at a range of locations, including hospitals, social services agency district offices, community health clinics at other community-based organizations and WIC and CalWORKs sites. These venues are targeted both because of the likelihood that a person who is seeking services there either for themselves or for a family member is income-eligible for public programs and because many of these organizations are trusted by the communities they serve.

County and community clinics are particularly common in-reach locales because those who seek care at clinics have an immediate health need or concern. Clinics and other safety net providers generally have made identifying uninsured clients a central component of their registration processes and rely on on-site eligibility workers. WIC and CalWORKs sites are also effective locations for in-reach since both programs work with low-income families whose children are likely to qualify for Medi-Cal, Healthy Families or Healthy Kids. Eligibility workers at these sites provide families with information on available health insurance programs and assist interested families in applying for coverage. Some CHIs have created "tell a friend" brochures or personalized business cards for their outstationed application assistors to share with the families they assist. These brochures and cards can be passed along by families to their friends and neighbors.

Community Outreach -- Getting the word out about the availability of health insurance in a way that families will trust and act upon is often a challenge. Common community outreach strategies that can be customized for specific populations include:

Promotoras: This form of community outreach relies on trained community residents to communicate with their neighbors about opportunities for health insurance for children. Known in Spanish as "promotoras," these outreach workers are important information resources for communities reluctant to seek assistance through in-reach venues and unlikely to either ask outreach workers they do not know about eligibility requirements or to share confidential information with them. Several CHIs have deployed trained promotoras to increase enrollment and improve retention in county Medi-Cal, Healthy Families and Healthy Kids programs.

Community events: Special community events such as Cinco de Mayo, the Vietnamese New Year and community health fairs are ideal venues for outreach workers to answer questions, dispel rumors about seeking insurance coverage, and identify those interested in pursuing applications for existing public programs and the Healthy Kids program. Several CHIs launched their Healthy Kids program outreach efforts at community health fairs where families could learn more about Healthy Kids, Medi-Cal and Healthy Families and set up appointments with application assistors or, in some cases, receive immediate application assistance.

Written materials: Flyers that provide easy to understand information about all available insurance programs, including the Healthy Kids program, in Spanish and English (and other languages if indicated by community demographics) and telephone contact information with the appropriate language competency are another useful component of community outreach efforts. Local stores, restaurants, churches and libraries are usually willing to post flyers and have additional copies available for those who request them. In addition to local outreach worker information or application locations, flyers include a CHI call center number or hotline. One centralized number, either an 800 number or local number, offers families a consistent way to obtain more information, have their questions answered or find out where they can receive assistance in their community.

School-Based Outreach – School-based outreach targets families with age-eligible children effectively. Major school-based outreach components include: (1) Request for Information (RFIs) flyers and health insurance surveys that are sent home with children and ask parents about their interest in obtaining affordable coverage for their children and other school mailings; (2) school-based events such as Back to School nights and Enrollment Fairs at which parents receive information from outreach workers about the availability of Medi-Cal, Healthy Families and the Healthy Kids program and can express an interest in applying; and (3) school liaison programs. A fourth school-based outreach program, Express Lane Eligibility, discussed elsewhere in this report, has recently been piloted in some California school districts as well.

School events: Schools can easily provide information on insurance coverage programs to parents during the many events they host during the school year. Back to School Nights, typically held in the fall, are a good opportunity to distribute information and discuss the need for health insurance with individual families. Schools also host events specifically for the parents of young children that provide a wonderful opportunity to educate them about the importance of health insurance while they are also learning about the necessity of immunizations and health screenings before kindergarten registration.

School liaisons and other strategies: Some CHIs work through a designated school liaison on school-based outreach efforts. Many school districts already are engaged in outreach activities for Medi-Cal and Healthy Families, primarily in schools with high rates of uninsured students, and their efforts can easily be expanded to include Healthy Kids program information as well. Many school districts already bill through Medi-Cal Administrative Activities (MAA) for their Medi-Cal outreach activities.

Targeted School Outreach: Santa Clara County's CHI has been able to maximize its outreach funding through a careful and sustained collaboration with Santa Clara County school districts and individual school partners. The CHI initially worked with all of the county's school districts to inform them of the initiative and to identify individual schools and districts to partner with in an ongoing outreach campaign. CHI partners worked with each school or school district individually to tailor education, outreach and enrollment efforts, to meet its needs and resources. Activities included surveying parents about whether their children were insured, as well as application events and presentations to school staff.

Express Lane Enrollment (ELE) – As described previously in this report, the pathways to enrollment in public health insurance coverage programs, ELE allows National School Lunch Program (NSLP) eligibility to serve as a proxy for Medi-Cal eligibility and provides temporary presumptive eligibility for those children who are deemed Medi-Cal eligible based on their participation in NSLP. The rationale behind the approach is that any child, regardless of citizenship or immigration status, who meets eligibility requirements for NSLP will most likely be eligible for Medi-Cal because of the similarity of eligibility requirements for the two programs. Thus with the proper information intake occurring locally, those children who meet all NSLP criteria could be quickly identified

for the Healthy Kids program, while those applicants eligible for Medi-Cal and Healthy Families could be identified and presumptively enrolled in those programs. Research is still underway to examine the necessary legal changes and confidentiality concerns of immigrant parents and guardians.

3. Eligibility Determination and Enrollment

As part of developing a comprehensive strategy to enroll children in available programs, CHIs have focused on creating an enrollment process that conforms to a single portal, is acceptable to all CHI partners and maximizes available federal, state and local funding. While their operational approaches to eligibility determination and enrollment vary, all CHIs have developed processes that first funnel potential eligibles through careful Medi-Cal and Healthy Families screenings to ensure that only children ineligible for Medi-Cal and Healthy Families will be enrolled in the Healthy Kids program.

Training is an essential element in ensuring that screening and enrollment processes and eligibility determination for Healthy Kids program are undertaken in a consistent manner and that children who are eligible for Medi-Cal and Healthy Families are enrolled in those programs. Application assistors and eligibility specialists must be trained in the program details for all three programs, be able to steer families to the most appropriate program and be able to fill out all program applications accurately to avoid delays in enrollment and denials.

Many counties have learned that training efforts can also work to create a culture change among application assistors. Involving application assistors in the planning and implementation of new assessment and enrollment processes strengthens the program and eases job change-related discomfort. Asking assistors to identify problems they are experiencing with the new systems, potential solutions and ways to improve the families' enrollment experience often increases assistor satisfaction and commitment levels.

Establishing a quality assurance process also helps with early identification of flaws and programmatic inconsistencies. The David and Lucile Packard Foundation funded the County Outreach, Retention and Enrollment (CORE) project to streamline enrollment and retention processes in children's health insurance programs. Alameda, San Mateo, San Francisco, Merced, Stanislaus and Santa Cruz counties participate in the project and have relied on recognized quality improvement methods to strengthen the enrollment and retention processes within their control and to share information and best practices across counties. The outcomes of this project have provided counties with improved practices resulting in increased enrollment and retention and reduced staff workloads.

Applicants still have the option of mailing in paper applications or, working with a trained CAA or county agency employee, completing an electronic application (Health-e-App) that separately assesses their eligibility for the Medi-Cal and Healthy Families programs and electronically submits applications for the programs. Health-e-App is a web-based system that allows families working with trained assistors to apply for Medi-Cal and

Healthy Families over the Internet and receive preliminary eligibility determination. Healthy Families applicants can also select providers and health, dental and vision plans. The electronic Health-e-App application has simplified and accelerated the eligibility determination process for applicants and those who assist them and has been a major improvement for those seeking entry into public programs. Some CHIs have overlaid a separate paper application process for the Healthy Kids program that is only completed if the applicant appears ineligible for Medi-Cal and Healthy Families. Others, including the San Mateo, Santa Clara, Alameda and Santa Cruz CHIs, have implemented or are in the process of implementing One-e-App. One-e-App is also a web-based system that interfaces with Health-e-App and allows families to apply for multiple programs through a single application. One-e-App can screen for a range of programs including Medi-Cal, Healthy Families, Healthy Kids, Food Stamps, WIC, ELE, CHDP and AIM.

Launching a Healthy Kids program creates an opportunity for integrating with the Medi-Cal and Healthy Families programs. This opportunity is fully realized through use of an integrated enrollment and eligibility determination process. Information technology planning and infrastructure considerations and the decisions made by the CHI and its strategic partners, particularly the participating health plan and the Social Services Agency or Human Services Agency, are at the core of ensuring integrated enrollment and eligibility determination. One-e-App, a web-based application, has been designed to interface with Health-e-App so that all those who apply using One-e- App are simultaneously assessed for eligibility for Medi-Cal, Healthy Families and Healthy Kids. One-e-App can be customized to perform eligibility determination for additional public programs. One-e-App also creates a countywide database for tracking outreach and retention and provides other management tools as well. While the costs and complexity involved in developing a universal eligibility assessment system may require CHI counties to move forward slowly, the integration potential between the Medi-Cal, Healthy Families and Healthy Kids programs afforded by such an approach cannot be over-emphasized. Without such a system, the CHI will need to rely on health plan databases for program tracking and monitoring information. Not all plans will have the necessary IT capacity to easily monitor and provide this information on a timely basis. For counties unlikely to be able to move toward developing an integrated enrollment system, it will be important to focus on the data capture and reporting capabilities of their health plan partner.

While the benefits of moving toward this approach are real and immediate with the program's launch, CHIs and their partners will need to be firmly committed to underwriting or seeking assistance in underwriting the costs of planning, hardware, local customization and annual maintenance that are incurred in implementing the system. A CHI can expect to devote time to developing local requirements, working with strategic partners and developing a detailed cost estimate for the project. Besides the obvious financial considerations, strategic partners may be concerned about what changes imposed on intake and eligibility determination procedures throughout the community may mean to their organization. These concerns may be particularly acute for the SSA where there may be concerns about the potential job assignment changes that will be required to support the new streamlined approach to eligibility assessment.

Santa Cruz County decided to launch its Healthy Kids program and its use of One-e-App technology simultaneously after learning of Santa Clara's and San Mateo's difficulties in converting from Healthy Kids paper applications to One-e-App. Rather than taking a sequential approach, Santa Cruz pre-launch activities included customizing One-e-App software for its Healthy Kids program and training staff on its use. When Santa Cruz County's program began operations in July 2004, all of its CAAs were completing online applications for families using the One-e-App technology. Santa Cruz CHI officials report that CAAs are pleased with the speed of the application process and report greater certainty that families are applying for the most appropriate program. Santa Cruz County's use of One-e-App has created a paperless application process for Medi-Cal, Healthy Families and its Health Kids program. Santa Cruz implemented One-e-App in seven weeks from start to finish.

In the absence of an integrated enrollment system, CHIs need to rely on a series of manual and electronic eligibility intake and assessment processes to determine eligibility for the Medi-Cal, Healthy Families and Healthy Kids programs. Since some CHIs, at least in the short term, will not be in a position to implement One-e-App, it will be crucial to develop the most streamlined approach possible for sharing applicant information and ensuring that the necessary data linkages exist to facilitate eligibility determination and enrollment for Healthy Kids eligibles while also guaranteeing that any applicants who are eligible for Medi-Cal and Healthy Families are not incorrectly deemed eligible for Healthy Kids.

4. Retention Strategies

Over time, the focus of a Healthy Kids program will change from outreach and eligibility determination to member retention. Renewal processes can dramatically and directly affect a program's retention rate. Programs should institute renewal policies and procedures that are both family friendly and easy to follow in order to retain eligibles under coverage. Most CHIs with effective retention strategies have incorporated the following principles into their renewal activities.

Renewal Simplicity – Make it easy and simple for families to renew. For example, mail out pre-filled renewal forms for parents to sign and return and include with every renewal form a local number to call and a site to visit if they need assistance with some aspect of renewal. This approach incorporates aspects of the simplification trend in renewal adopted by some state Medicaid and SCHIP programs.

Built-In Leniency – Design renewal and premium payment policies that give families some latitude in meeting deadlines. Start the renewal process early (three months before deadline) to give families time to respond. Create systems that contact parents when renewal forms have not returned by a certain date (prior to the renewal deadline) and plan to assist late-responding parents to help them retain their children's coverage.

Early and Frequent Communication – Determine what entity will take the lead for the renewal process and ensure that the entities performing outreach and enrollment

activities are also involved. Contact families through different venues: mail out forms and reminder postcards; call families who have not returned renewal forms; and post flyers throughout the community with information on how and where to renew. If a CHI decides to collect information at renewal time, communicating what is needed to the families becomes incredibly important. Suggestions to create an effective mail-in renewal form include formatting the renewal form as a checklist in which parents can check off all the information they are required to submit; sending renewal forms home in a color envelope and printing the forms on color paper to attract attention; enclosing postage-paid, self-addressed envelopes in the renewal packet; and sending reminder postcards two weeks before and two weeks after the renewal forms are mailed. Ensuring that families receive renewal forms that are language appropriate will expedite the renewal process and prevent children from being inadvertently disenrolled.

Frequency of renewal requirements also affects retention levels since more frequent renewals increase a child's chance of disenrolling through accident or oversight. Short renewal periods also increase a CHI's administrative burden. Most CHIs have opted for an annual renewal period for their Healthy Kids programs consistent with Medi-Cal and Healthy Families policy but at least one, Los Angeles, has selected a six-month renewal period.

Premium payments and the corresponding systems and policies will also have an impact on retention. Monthly premiums provide a consistent means of staying in touch with a family but also increase the chance that the family may not pay their premium and will disenroll. Having less frequent premium payments eases the burden on the families and promotes continuity of care as well as decreasing the administrative burden of the CHI in processing premiums. Some CHIs have set up incentives for families to pay their premiums in one lump sum with offers of paying for the first three quarters of the year and receiving the fourth quarter for free. Making it easy for families to pay their premiums, by providing premium payment coupons, for example, will also help with retention rates. Establishing a hardship fund for families who are unable to pay their premiums and publicizing it will help to ensure continuous coverage for the most needy.

In addition to creating policies and procedures that assist the family in maintaining coverage, using the same single entry or portal approach that was successful in outreach efforts can also work in member retention efforts. Ensuring that every application assistor can help families with the renewal and that all partnering groups – the social services agency, CBOs, schools – are kept up-to-date on the renewal process, policies and how to assist families in keeping their children covered is critical. The outreach strategies the CHI developed – in-reach, promotoras, joint outstationing of application assistors – can also be used to inform parents about the importance of renewing their child's insurance and provide assistance with the renewal process. Because of their member-friendly approach, outreach workers who maintain communications with applicant families can play an important and cost-effective role in member retention. For example, through callbacks to enrolled families, outreach workers can: remind families to pay their premiums; make sure that children receive all appropriate preventive and age-appropriate diagnostic services; and provide a linkage

to other information that eligibles may require, such as how to request a deferment on premium payments due to a change in job status.

A tracking system provides a CHI with critical information about why and when enrollments occur. Knowing what percentage of children dis-enrolled for avoidable reasons allows the CHI to take steps to better work with families to retain their children in coverage. Many operational CHIs track a variety of disenrollment categories on a monthly basis, including: age-outs, failure to pay premiums, moves out of county, change in income and unable to contact. Outreach workers and application assistors may also be able to offer valuable insights into reasons for disenrollment and ways to increase retention.

Improving Service Utilization and Retention--In January, 2003, Santa Clara Family Health Plan implemented a dedicated outgoing and incoming call center into its Healthy Kids Program to encourage appropriate health care utilization and enrollee retention. Outgoing call center staff conduct call campaigns about proper utilization and remind families to return their children renewal packets. Separate call center staff receive inbound Healthy Kids calls from the plan's 800 number.

Member Services contacts families immediately prior to their insurance becoming effective to verify and update contact information, assist families in choosing a doctor, inform families of premium payments and renewal process and to encourage them to go to a new member orientation. Call centers provide a good opportunity to answer a family's questions, assist them in accessing services and remind them of available resources.

At renewal time, Santa Clara Family Health Plan sends out two rounds of renewal packets, 75 and 45 days before a children's annual renewal date. Renewal forms are pre-filled with data currently in the Plan's Healthy Kids database, families just have to update this information. If families do not respond to those mailings or if they submit incomplete packets, the call center contacts the families during the month before the family's termination date. The first call is made 30 days before termination and if no response is received, another call is made two weeks before termination. During the final week before termination, additional calls are made to families who have not yet responded encouraging them to go to an enrollment site and complete the renewal form. Call center staff are fluent in Spanish and Vietnamese and telephone interpreters are available for those who speak other languages.

8. What Are the Scenarios for Insuring Low-income Children?

What are possible ways for health care coverage to be provided to uninsured children in Merced County? This report describes five possible scenarios for bringing together an insurance program for uninsured low-income children not qualifying for Medi-Cal or Healthy Families with one or more health systems to deliver care.

- Use CaliforniaKids (CalKids);

- Offer Healthy Kids product through commercial health plans operating in Merced County;
- Offer a Health Kids product through a single commercial health plan and transfer Healthy Kids to the Medi-Cal managed care plan in the future;
- Purchase Healthy Kids through the proposed MRMIB Buy-In (e.g. Healthy Families Look-Alike); or
- Postpone offering a new uninsured children's coverage until a Medi-Cal managed care plan is developed for Merced County.

The options run the gamut from starting a limited and inexpensive Healthy Kids program as soon as possible to postponing a children's health insurance program until a more ideal system, incorporating Medi-Cal managed care and Healthy Kids, can be created. Each of these five scenarios is summarized below. A more detailed presentation of the advantages and shortcomings of each is detailed in Table 8-1.

Scenario #1 – CaliforniaKids (CalKids)

CaliforniaKids would be the sole administrator of the children's health insurance benefit. CalKids is limited to children from ages 2-18 and whose families' income is below 250% FPL. While inexpensive and more easily implemented, CalKids has several additional disadvantages, including a limited scope of benefits and inability to qualify for private foundation and AB 495 funding. CalKids uses the Blue Cross EPO network in Merced County, which has been awarded the Healthy Families Community Provider Plan designation by MRMIB because it includes the best participation of traditional and safety net medical providers.

Scenario #2 – Healthy Kids Through the Use of Commercial Health Plans Operating in Merced County

The use of commercial health plans would most likely focus on current Healthy Families participating health plans. Currently the Healthy Families plans are Blue Cross EPO, Blue Shield EPO and the HealthNet HMO. This scenario is predicated on the interest of multiple health plans to participate. Unlike other most other counties which have developed Healthy Kids programs, Merced County does not have a publicly-sponsored Medi-Cal managed care plan to be the sole health plan provider for Healthy Kids. All current Healthy Families participating health plans are commercial health plans, rather than publicly-sponsored. Under this scenario, some infrastructure would be needed to make eligibility determinations and to then communicate the decision to the selected health plan. Some mechanism would have to be established to contract with vision and dental plans. CHI would have a spillover effect by increasing Healthy Families enrollment which would increase enrollments in the Medi-Cal and Healthy Families participating health plans.

Scenario #3—Use of Scenario #2 with a Single Health Plan and Transfer Healthy Kids to the Medi-Cal Managed Care Plan at Some Point in the Future

This scenario would involve the use of a request for proposals (RFP) process and the selection of a single health plan from among those currently participating in Healthy Families in Merced County. In this fashion, all the new Healthy Kids enrollees would join

a single plan. Of course, this scenario is predicated on the interest of at least one health plan to participate under the conditions established in the RFP process. These conditions could include network participation of traditional and safety net health care providers and subcontracting with dental and vision plans. The selected plan would benefit by receiving all the new Healthy Kids enrollments. The successful plan could also benefit from a more favorable number of Healthy Families enrollments as a spill-over from the Children's Health Initiative campaign and the added publicity.

Scenario #4 – Healthy Kids Through MRMIB Buy-In (e.g. Healthy Families Look-Alike)

Under this scenario, local funds would be used to buy-in to the Healthy Families program on behalf of children in Merced County who did not qualify for Medi-Cal or Healthy Families because of family income level or immigration status. Children would enroll in any of the health, vision and dental plans that participated in Healthy Families in the county. By limiting the participating health plans to those in the Healthy Families program, there would not necessarily be a linkage between Medi-Cal managed care and a Healthy Kids product. While MRMIB's target implementation date is July 1, 2006, a delay to at least January 1, 2007, is very likely.

Scenario #5— Postpone Developing New Uninsured Children's Coverage Until a Medi-Cal Managed Care Plan is Developed for Merced County

This scenario calls for the integration of a CHI with the operation of a Medi-Cal managed care plan serving Merced County. Merced County has been designated for Medi-Cal managed care expansion by DHS. This new health plan could be given the sole authorization to enroll Healthy Kids. Presumably, the health plan would also seek to participate in the Healthy Families program and be awarded a contract by MRMIB. In this way, the new Medi-Cal managed care plan could be available to families who have children enrolled in any of the three programs. In effect, this scenario would mean a delay in implementing a formal CHI and developing a "gap coverage" product until all needed funds could be secured and a local Medi-Cal managed care plan is online.

Table 8-1
Merced County
Health Plan Scenarios Under A CHI Umbrella
Advantages and Shortcomings

Scenarios	Advantages	Shortcomings
Scenario #1 – CaliforniaKids (CalKids) CaliforniaKids (Blue Cross EPO panel) would be the sole plan provider of the children's health insurance benefit.	• Statewide experience • Easiest to start-up and bring online faster • Less expensive because benefits are not as comprehensive • No Knox Keene licensure impediments, but also no similar regulatory protections	• CalKids provider panel would likely differ from the Healthy Families and Medi-Cal provider panels. This means children in the same family, but eligible for different programs, might not have the choice of the same provider. • Does not offer broad, comprehensive benefit package • Would not qualify for AB 495 funds, State First 5 Commission match funds, or The California Endowment premium subsidies • Would probably not meet the qualification standards for private foundation funding by major California foundations supporting "gap insurance" products • Would not benefit from the spillover effect of increased Healthy Families enrollment triggered by CHI
Scenario #2 – Healthy Kids Through Use of Commercial Health Plan(s) Operating in Merced County	• Fewer outstanding Knox Keene licensing unknowns • Some degree of private provider familiarity • Could qualify for AB 495 if a permissive interpretation of MRMIB's AB 495 State Plan Amendment is allowed • One or more Healthy Families plans would benefit because of the CHI enrollment campaign • If a Healthy Families benefits package was adopted, would qualify for AB 495 funding • Would meet the standards of California private foundations and State First 5 Commission matching funds for financial support	• Health plan selection process could be time consuming • Health plans might not have extensive experience with prospective Healthy Kids enrollees, unless provider networks already include safety net providers • Development time could be extended without adequate existing provider network for children • Some question about AB 495 qualification • Unlikely to ensure use of same physician for different children in same family enrolled in different programs (Medi-Cal, HF, new product)

Scenarios	Advantages	Shortcomings
	• If "any willing" health plan is permitted to participate, health plan selection could avoid controversy • A Healthy Families participating plan would benefit from the spillover effect of increased Healthy Families enrollment triggered by CHI	• Most likely separate contracts will be necessary for health, vision and dental plans • Uninsured children in the same family could be enrolled in different health plans
Scenario #3 – **Use of Scenario #2 with a Single Plan and Transfer Healthy Kids to Medi-Cal Managed Care At Some Point in Future**	• Permits the most rapid implementation of a Healthy Kids product • Some degree of private provider familiarity • Could qualify for AB 495, but only if a permissive interpretation of MRMIB's AB 495 State Plan Amendment is allowed • All Healthy Families participating plans will benefit because of the CHI enrollment campaign • Would meet the standards of California private foundations and State First 5 Commission matching funds for financial support • A Healthy Families participating plan would benefit from the spillover effect of increased Healthy Families enrollment triggered by CHI	• Could require competitive bid process • Could require transfer to a new Medi-Cal managed care plan at some point in the distant future • A commercial plan might not qualify for AB 495 funds • Health plan selection process could be time consuming • Health plans might not have extensive experience with prospective Healthy Kids enrollees, unless provider networks already include safety net providers • Unlikely to ensure use of same physician for different children in same family enrolled in different programs (Medi-Cal, Healthy Families, new product) • Most likely separate contracts will be necessary for health, vision and dental plans
Scenario #4 – **Healthy Kids Through MRMIB Buy-In ("Healthy Families Look-Alike")**	• Could meet state strategic goals • MRMIB would use participating Healthy Families health plans, dental plans and vision plans • MRMIB would use the community provider plan concept to reward the health plan which includes the most safety net and traditional providers to low-income residents • Easier for providers and application assistors to understand with more seamless program administration • Program policy Infrastructure would be in place, thereby reducing need for and cost of local eligibility and renewal infrastructure	• May not be a business interest of Health Families participating health plans • Would not result in local control / accountability which could dampen private fund raising prospects • MRMIB would need program permitting enrollment of illegal immigrants, higher income threshold, etc. • Implementation requirements and timeframe at state level could be slow • No direct linkage between Medi-Cal managed care and Healthy Kids

Scenarios	Advantages	Shortcomings
	• Offer a wider selection of plans • Provider familiarity with Health Families participating providers and program rules • With Federal approval, access to AB 495 funding • Costs of local enrollment processing would be minimized, depending how state and locale split enrollment and renewal functions • Would meet qualification standards of California private foundations and qualify for their financial support • Use of multiple health plans limits exposure to potential program disruption with use of single plan • Creates competition among health plans	• Limiting market share for participating plans could lead to higher rates on a per enrollee per month basis demanded by plans, reducing opportunity for volume discount • Integration of a retention program would not fit with Healthy Families Buy-In
Scenario #5 – Postpone Developing New Uninsured Children's Coverage Until a Medi-Cal Managed Care Plan is Developed for Merced County	• Provides time for resolution of Medi-Cal managed care expansion in Merced County • Conforms to the integrated approach between Medi-Cal managed care and Healthy Kids adopted in other counties with publicly-sponsored Medi-Cal managed care plans • Wouldn't have to go through transition to new health plan • Allows more fundraising and the rollout of a more universal "gap coverage" program • CHI campaign could proceed to identify children eligible for Medi-Cal and Healthy Families • Builds on successful infrastructure and experience of HCAP to continue sustained outreach and enrollment in Medi-Cal and Healthy Families	• Duration of delay in starting health insurance product could be prolonged for a variety of reasons, including development of Medi-Cal managed care plan, need for operational experience, financial solvency, staff recruitment, etc. • If other scenarios were adopted as temporary, transition to another scenario would be disruptive • CHI would have the effect of potentially identifying uninsured children not eligible for Health Families or Medi-Cal, but not having available gap coverage • DHS may object to adding new product line until sufficient experience is gained by a publicly-sponsored Medi-Cal managed care plan • DMHC might delay approval of new product lines pending demonstration of adequate financial and management experience by relatively new Medi-Cal managed care plan.

9. Enrollment and Cost Projections

This section presents estimates of the annual health insurance premium costs of a program to enroll all children under 300% of the FPL in a new health insurance program. Other CHI costs like outreach, application assistance, enrollment processing, renewal assistance, retention, fundraising and related administrative costs, are not discussed here.

Estimates for the number of uninsured children are derived from the California Health Interview Study (CHIS) conducted by UCLA's Center for Health Policy Research. These are the most referenced health data in California on the level of uninsurance. In this report, actual CHIS data is used in conjunction with California Department of Finance population projections for Merced County. In combination, these data produce the uninsured enrollment targets for the age group, 0-18 years. The calculation results in an estimate of 2,800 uninsured children in Merced County not eligible for Medi-Cal or Healthy Families. [See Table 2-3, in Section 2, above]. About 20% of the uninsured children are in the 0-5 year old age cohort.

Based on scenarios 1-5 (see Section 8), there are two possible benefit plans that can be used in projecting annual premium costs for a children's health insurance expansion product. The first benefit plan is represented by Cal Kids which is available only to children between 2-18 years (a cohort comprising about 95% of all uninsured children) and would offer a limited range of health, vision and dental benefits (see Attachment I, *Comparison of Children's Coverage Programs Summary of Benefits and Costs to Members*). The annual premium cost would be approximately $540 per child. Table 9-1 summarizes the annual cost of a Cal Kids only scenario. Based on the estimated number of low-income uninsured children who could qualify for enrollment in a new health insurance program, Table 9-1 depicts actual enrollment over a multi-year period. The projections culminate at some point after the third year in full enrollment of the currently projected number of low-income children who are not eligible for existing public health insurance programs. The assumption is that full enrollment will not occur immediately. This assumption could, of course, vary depending on factors such as the success of outreach and enrollment campaigns and the availability of funds. At full enrollment of uninsured children in Merced County, except for children under 2 years, the total annual health care premium cost would be about $1,436,400 in 2005.

Table 9-1
Merced County
Projected Annual Program Enrollment and
Total Annual Health Insurance Premiums for Cal Kids

Uninsured Children Ineligible for Public Programs	Uninsured (2-18 years)	Total Annual Health Insurance Premium
Year 1 25% Enrollment	665	$359,100
Year 2 25% Enrollment	1,330	$718,200
Year 3 75% Enrollment	1,995	$1,077,300
Full Enrollment	2,660	$1,436,400

The second benefit plan is represented by the Healthy Families scope of benefits (using health, vision, and dental) which is the standard among counties which have developed children's health insurance expansion products. (See Attachment I, *Comparison of Children's Coverage Programs Summary of Benefits and Costs to Members*). The annual per child cost of that benefit package in Merced County in 2005 is estimated at $1,104. All qualified children between 0 and 18 years would qualify. Under scenarios 2, 3, and 4, Healthy Families participating health plans would be unlikely to offer a different set of benefits.

Based on the estimated number of low-income uninsured children who could qualify for enrollment in a new health insurance program, Table 9-2 below, projects actual enrollment over a multi-year period. The projections culminate at some point after the third year in full enrollment of the currently projected number of low-income children who are not eligible for existing public health insurance programs. The assumption is that full enrollment will not occur immediately. This assumption could, of course, vary depending on factors such as the success of outreach and enrollment campaigns and the availability of funds. Using a Healthy Families-like scope of benefits, at full enrollment of uninsured children in Merced County, the total annual health care premium cost would be about $3,091,200 in 2005.

Table 9-2
Merced County
Projected Annual Program Enrollment and
Total Annual Health Insurance Premiums for Healthy Families Benefits

Uninsured Children Ineligible for Public Programs	Uninsured	Total Annual Health Insurance Premium
	2,800	
Year 1 25% Enrollment	700	$772,800
Year 2 25% Enrollment	1,400	$1,545,600
Year 3 75% Enrollment	2,100	$2,318, 400
Full Enrollment	2,800	$3,091,200

Health insurance premium costs could change over time. Certainly, the premium costs could vary if the benefit packages are modified compared to the assumptions used for this feasibility analysis. The total costs of a Children's Health Initiative would have to factor in the cost of an administrative infrastructure in addition to the resources presently committed to outreach, application assistance, and enrollment by county agencies, health care providers, and community-based organizations.

10. Funding: The California Experience and Issues Facing Merced County

This section describes the lessons learned from other California counties which have developed Children's Health Initiatives with a gap insurance product and an analysis of the funding issues facing Merced County.

A. Funding Lessons Learned from Other California Counties

Financing is always the first major hurdle faced by start-up ventures. Like all new ventures, Healthy Kids programs have benefited from the creativity, vision and determination of those who worked to obtain financing for them. While their approaches have varied and their efforts have often met with resistance, at least initially, the message is clear: CHIs made up of committed organizations and influential community members can bridge the financing gap and create local coverage programs for children.

1. Financing Components

Essential CHI financing components and strategies are: 1) securing planning and anchor funds; 2) securing local funds; 3) securing external funds; 4) program staging to match financing with enrollment levels; 5) adjusting to funder restrictions; 6) evaluating "fund holder" options; and 7) developing long-term sustainability. While all seven components are essential, only the first six are necessary for start-up. Remarkably, CHIs have assembled a varied mix of funders. Table 10-1 below lists the funding sources that have been tapped by operational CHIs. The actual funding mix and the amounts they individually provide to the initiative are a result of each county's economic, demographic, political and organizational environment.

2. Planning and Anchor Funding

One major early role of CHI leaders and political champions is identifying and cultivating financial support for planning activities. A planning grant supports necessary staff and outside experts and also demonstrates that funders have found merit in the proposed planning activity. CHI planning grants have come from a variety of local sources including local First 5 Commissions and community and private foundations. San Mateo and Fresno CHIs also used Federal Healthy Communities Access Program (HCAP) grants to fund their planning activities. Merced County also has received HCAP funding. Organizations participating in the CHI may also provide financial and in-kind staff – support through each of the planning and implementation stages. Merced County has received planning funds from the California HealthCare Foundation.

As planning progresses and the initial budget requirements of the CHI are projected, CHI organizers will develop list of prospective local and external public and private funding sources and explore the feasibility of accessing these sources within the community coalition. CHIs should strive to obtain the support of at least two or three major funders. This list serves as the key to identifying potential major anchor support

for program implementation and operation. Receiving anchor funding helps CHIs encourage other probable funders to “come to the table” and contribute. CHIs have generally received anchor funding through the local First 5 Commissions, along with matching funds from the State First 5 Commission, to support their planning and implementation efforts and, in several cases, also to support several years of operation. County First 5 Commissions have been a financial cornerstone for every CHI operating in California.

Table 10-1
Funding Sources for
Children’s Health Initiatives in California

	Statewide	**Local**
Public	California Children & Families First Commission (First 5 California) AB 495 (C-CHIP)	County First 5 Commission County General Fund Local Healthcare (Hospital) Districts Health plans Master Tobacco Settlement Allocations
Private	The David and Lucile Packard Foundation The California Endowment Blue Shield of California Foundation California Healthcare Foundation	Community Foundations Corporations Individuals

Hospitals in the community may also prove a source of funding since hospitals commonly provide hundreds of millions of dollars annually in uncompensated care statewide while caring for uninsured and underinsured children. Non-profit hospitals must provide “community benefits” to satisfy their tax-exempt status and must plan how best to spend those benefit resources with their community. District hospitals, which are publicly owned, may have resources to support health insurance coverage for children in their service area. In San Mateo County, for example, two district hospitals have contributed significantly to the CHI.

Other local funders include community foundations, business and philanthropies. California has also received some $950 million dollars in Tobacco Settlement funds. Individual counties have used their allotments in a variety of ways, including health service provision. Careful coalition building and strategic champion selection may enable a CHI to receive some of these funds.

Perhaps most importantly, the existence of committed local funding has helped leaders and political champions to solicit matching funds and other resources from outside the community. It is the amassing of collective local resources – financial, in-kind and political – that demonstrate local commitment, build momentum and attract other sources of financial support.

3. Complementing Local Funds

Most CHIs have worked to balance local funding with a mix of state (both public and private) and federal resources. Four private foundations – including The David and

Lucile Packard Foundation, The California Endowment, the California HealthCare Foundation and the Blue Shield of California Foundation – have each made multi-million dollar investments in children's coverage statewide. Individual county First 5 Commissions have also made children's insurance coverage a priority. Cumulatively, local First 5 Commissions have invested over $50 million annually to CHI planning and premium support for children under age six. Significant resources have also been allocated by the California Children and Families Commission (State First 5 Commission) through its Health Access for All Children program. Announced in early 2004, the Commission has established a four year, $46.5 million matching investment program to assist with premium subsidies for children birth to age five who are ineligible for Medi-Cal and Healthy Families and who are in families with incomes below 300% FPL.

CHIs have arranged state funding support for Healthy Kids enrollees who have special needs by working with the local California Children's Services (CCS) program. Through a formal, written understanding between the health plan and the local CCS office, a process is established to ensure that CCS-eligible children who are at risk for or who have serious, chronic and disabling physical conditions or diseases have their CCS-eligible services paid for by that program. In this way, the CCS-eligible services required by these children are effectively "carved out" of the scope of benefits provided by their health plan and the plan is relieved of the financial responsibility for CCS-covered services. Healthy Kids eligibles will need to apply to a county CCS office and be accepted before being CCS-qualified.

Federal funding through the Medicaid Administrative Activities (MAA) program may also play a role in Healthy Kids programs because of the links between outreach and enrollment provided to Medi-Cal and Healthy Families eligible children and Healthy Kids eligible children using a single entry point to outreach, enrollment and retention activities. MAA is a state-administered, federal cost reimbursement program for counties, community-based organizations and school districts involved in administering the Medi-Cal program. MAA reimbursements return to local human services agencies as unrestricted dollars. Under a single entry point concept, the activities which screen Medi-Cal, Healthy Families and Healthy Kids eligibles, some of the costs associated with Medi-Cal eligibility screening can be reimbursed by MAA.

4. Program Staging

Each of the established CHI counties initially raised sufficient funds for outreach and enrollment efforts and to cover a majority of the total expected Healthy Kids enrollment. Given that marketing and outreach to Healthy Kids-eligible children takes time, financing the cost of premium subsidies can be staged over several years. Los Angeles County, for example, launched the CHI first for children 0-5 and then for 6-18 year olds nearly a year later. This staging allowed CHI leaders and political champions to systematically raise resources for the older population.

As in Los Angeles County, launching with limited funding must be accompanied by aggressive sustainability and fundraising plans. Typically, multi-year funding (up to five

years) may be more readily secured for the 0-5 population, and thus fundraising efforts will generally focus on 6-18 year olds. In addition, contingency plans, such as enrollment caps and waiting lists, should be outlined in the event that funds become limited. Unlike the Medi-Cal program, county Healthy Kids programs are not entitlement programs. This distinction ensures that CHIs can limit enrollment to match the available funding.

CHIs have been launched with partial funding. With funding secured for essential program elements and a portion of the premium costs, the momentum created by a successful launch is invaluable in creating the goodwill necessary to raise additional resources. Furthermore, CHI planning should realistically stage launches and enrollment expansions to match immediately available and potential resources.

5. Funder Restrictions

Potential funding may come with restrictions such as age or location of residence, that affect the program design and how the resources are specifically used. First 5 funds for example are statutorily restricted to children under six years of age. If First 5 funds serve as the anchor grant, the initial program launch may be restricted to children under six years old. Los Angeles County launched its Healthy Kids program with this restriction in July, 2003 and launched enrollment for 6-18 year olds nearly a year later. Similarly, Kern County began its Healthy Kids Program with coverage only for children in the 0-5 year old age group. This age specific restriction requires CHI leadership to find funding specifically for the 6-18 year old population. Moreover, CHIs with anchor funding from First 5 should be careful to ensure that the initiative's overall objectives remain broadly focused on children birth to age 18. If funding for the 6-18 year old population is raised incrementally, the CHI leadership will have to address how to best use the funds incrementally. In other words, if funds are not sufficient to cover the entire 6-18 year old population, some choices for their use include: covering siblings of Healthy Kids enrollees under age 6; continuing Healthy Kids coverage for children after they turn 6; or covering a subset of eligible 6-18 year olds and keeping the remaining applicants on a waiting list.

6. Fund Holder Options

Each CHI must address how to legally administer funds raised for the initiative and make payments to contractors, such as the selected health plan and community-based organizations. Specifically, an identified organization will hold and manage funds directed to support the initiative. The chosen fund holder assumes responsibility for disbursing some or all of the funds, tax reporting and fiscal monitoring of CHI projects. Established CHIs have created various fund holding arrangements. The three main options are (1) to contract with a local community foundation or (2) a local agency, or (3) to establish a 501(c) (3) charitable organization to meet the fund holding public responsibilities.

7. Long-term Sustainability

The most important issue for all operating CHIs that have Healthy Kids programs is ensuring long-term program sustainability. None of the CHIs has yet secured adequate long-term financing. Healthy Kids programs are relying in large part on transitional or "bridge" funds while CHIs work to achieve long-term sustainability.

Cultivating potential long-term funders requires soliciting the support of the general public as well as the support of political representatives and other influential community leaders. This can be accomplished by successfully marketing the program's objectives, demonstrating the value of investing in children' s coverage and specifying the economic benefits to the community. Committed and potential funders may benefit from periodic reports on CHI enrollments, total secured funding to date and the overall return on investment in children's coverage.

B. Funding Issues for Merced County

The identification of potential funding sources is based on a review of actual funding sources for Healthy Kids products elsewhere in the state and circumstances presented in Merced County. Table 10-2, on the following page, summarizes some potential sources available for consideration in Merced County. Funders are categorized according to local and statewide focus.

Local

- First 5 Merced County Children and Families Commission
- Local health care districts
- County Board of Supervisors
- Local businesses and service clubs
- Other local contributions

Statewide

- State First 5 Commission
- AB 495 (C-CHIP)
- California Healthcare Foundation
- The California Endowment
- Blue Shield of California Foundation
- David and Lucile Packard Foundation
- Catholic Healthcare West

Table 10-2
Potential Funding Sources for Uninsured Children in Merced County

	Age Restrictions	Other Restrictions
--LOCAL--		
First 5 Merced County Children and Families Commission	0-5	None
Local health care districts		
County Board of Supervisors		
Local businesses and service clubs		
--STATE--		
State First 5 Commission	0-5	*Match local funds*
AB 495 / C-CHIP Federal funding (with a 35% local match) is available for legal residents only from families below 300% of the FPL through the AB495 project administered by the MRMIB. Law provides mechanism to permit county agencies, local initiatives and county organized health systems to utilize unexpended Healthy Families funds for coverage expansion. Contingent on CMS approval.	None	Legal Residents Only; *CMS would require Healthy Families-like product. Funds at local level administered through county.*
California Healthcare Foundation	None	Healthy Kids/ Health Families Look-alike; no other pattern of restriction
The California Endowment	None	Healthy Kids/ Health Families Look-alike; no other pattern of restriction
David and Lucile Packard Foundation	None	Healthy Kids/ Health Families Look-alike; no other pattern of restriction
Blue Shield of California Foundation	None	Premiums, outreach and enrollment; Matching funds preferred
Catholic Healthcare West		

It is important to keep in mind that some funders have restrictions on the use of funds. For example, funds from First 5 Merced County are restricted to supporting children 0-5 years. This is approximately 20% of the uninsured children. Therefore, fundraising would have to target children 6-18 years (80% of the total) if the health insurance program expects to provide universal coverage.

11. Opportunities and Challenges in Merced County

As it considers the steps to take to improve the health care system for all its children, Merced County is faced with many opportunities and challenges.

Demographically and economically, Merced County has some serious disadvantages to overcome. Consider the following:

- Per capita income is low, at only 61.5% of the California average;

- Based on data from 2004 and from the first quarter, 2005, Merced County continues rank among the four or five counties in California with the highest rate of unemployment; and

- At 32.1%, Merced County has the second highest county rate of Medi-Cal enrollees per county population in California, an indicator of extensive low income.

Low-income persons are less likely to have health insurance. Further, many children in the community, though low-income, are not eligible for either Medi-Cal or Healthy Families, two of the most well-known public health programs for low-income residents. Many low-income children who would benefit if a health care coverage program could be designed to fill the gap left by Medi-Cal and Healthy Families. Based on the findings in other counties, thousands of children in Merced County, more than likely, may even be eligible for Medi-Cal or Healthy Families, but are not enrolled.

With the seriousness of the challenges facing low-income children lacking health insurance, Merced County will want to accelerate action as soon as possible to ameliorate the problems. However, to be successful and prudent, it will have to temper the eagerness, if not desperation, with the reality of needing resources and a state policy environment that will change over the next half dozen years.

In reviewing the opportunities and challenges presented today to Merced County, it is important to keep in mind some important questions that will influence decision-making going forward:

- How will the urgency and severity of the need for an expanded children health insurance program influence the planning process? How can time be used best?
- How can the eventuality of Medi-Cal managed care be integrated with Healthy Kids and CHI, as it has in many other California counties?
- How can Merced County build the infrastructures required to operate a CHI and oversee a publicly-sponsored Medi-Cal managed care plan? What local resources can be used?
- What amount of funding must be raised to organize a CHI and develop a children's health insurance product and what restrictions might be placed on donated or granted funds?
- What measures will assure that the policies of the CHI effort will be responsive and accountable to the needs of Merced County?

A. Building a CHI

Under the leadership of the Merced County Health Care Consortium (MCHCC) and First 5 Merced County, creating a children's health insurance product is a natural extension of the work currently underway by First 5 Merced County, Health Care Access Coalition (HCAC) and MCHCC. MCHCC has demonstrated the capability of building and channeling the effort to expand health insurance expansion for children through a

countywide collaboration that avoids duplication of effort. Its focus on increasing health insurance coverage has already been the force behind reengineering the enrollment system in Merced County for Medi-Cal and Healthy Families. A CHI in Merced County has the opportunity to build on the progress of MCHCC as well as HCAC. In addition, the Healthy Communities Access Project (HCAP) has operated a successful outreach, enrollment, assistance and retention program aimed at low-income residents through a collaboration of key health and social services agencies. The experience gained through HCAP lays the groundwork for the CHI campaigns ahead. Merced County has the opportunity to take advantage of calls for action from many different quarters. Statewide advocacy groups like Californians for Healthy Kids lend strong credence to the movement to expand health insurance coverage for children. Pending state legislation (SB 437, AB 772 and AB 1199) intended to set policy for the California Health Kids Insurance Program have garnered bi-partisan support.

B. Health Plan Scenarios

Unlike other counties which have implemented CHI and offered a gap insurance product for low-income children, Merced County does not currently have a local health plan with which to partner easily. This would appear to be a major disadvantage. In the previous section, several scenarios were identified in which commercial health plans could help solve this problem. Perhaps the easiest, and arguably the least expensive, solution would be to use CalKids to administer the gap coverage program. The attraction of this approach is that CalKids is inexpensive and the provider network, the Blue Cross EPO, is already in place. However, CalKids has at least three important weakness: the covered age group is restricted to children 2-18 years, the benefits are not as comprehensive as Healthy Families or Medi-Cal and the program is not eligible for some state funding. Blue Cross EPO, Blue Shield EPO and Health Net HMO currently provide Healthy Families coverage in Merced County. Blue Cross and HealthNet sponsor Medi-Cal managed care plans and CHIs in neighboring counties. One or more of these plans could provide the gap coverage in the short term, if willing and if funds were available. Would the selection of one plan be preferable to two or three plans? Would the cost be less with fewer plans? The option of using commercial plans is tempting because the gap coverage insurance could be implemented sooner, if funding was available. MRMIB's support for a "Healthy Families" buy-in program offers an administratively simple approach for furnishing gap coverage, though it might not be the best fit with Medi-Cal managed care and the timeline for implementation is uncertain.

However, another factor must be considered: DHS has announced that it plans to expand Medi-Cal managed care into Merced County and wants to know the county's preference among the possible models by September 1, 2005. The raises the question: How would such a Medi-Cal managed care system integrate with a new children's health insurance plan? As noted previously, in most other California counties in which a gap insurance program has been developed, the local, publicly-sponsored Medi-Cal managed care plan has been the exclusive plan provider. In light of the DHS announcement, Merced County could choose to have a publicly-sponsored Medi-Cal managed care plan which would be accountable to the Board of Supervisors, members and the community, including health care providers.

The opportunity of eventually using the Medi-Cal managed care system brings the discussion back to whether there is a short-term solution: could commercial plans be used until a Medi-Cal managed care plan is developed? And what are the risks of a Medi-Cal managed care plan? While the financial risk of operating a Medi-Cal managed care plan is palpable, and solvency is closely tied to the adequacy of rates paid by the State, in the past fifteen years, no Medi-Cal managed care plan has ceased operation. So can a locally sponsored Medi-Cal managed care plan be financially feasible? If Merced County sponsors a Medi-Cal managed care plan, from what source will it obtain development funds and how much will be necessary to develop the preferred model? If loans are involved, will the plan begin operations with too much debt? In any event, even if funding is available, development of a Medi-Cal managed care plan will require two to three years and knowledgeable staff assisted by experienced consultants. A new Medi-Cal managed care plan would need time to stabilize its Medi-Cal business before adding Healthy Families and Healthy Kids coverage products. Until a Medi-Cal managed care plan is operating and could add a new gap coverage product, low-income children would remain uninsured. Health care providers throughout the county have endorsed a children's health initiative and Medi-Cal managed care, if organized acceptably. Is Merced County willing to wait until the Medi-Cal managed care questions are resolved?

So Merced County faces a dilemma when considering how Medi-Cal managed care should affect the timing of efforts to expand health insurance to low-income children: On the one hand, not only are time and resources necessary to implement Medi-Cal managed care, but time is also necessary to raise funding to support children 6-18 years who would not be covered under funds committed by Merced First 5 Commission. On the other hand, the problem of high rates of uninsurance is so significant that there is an urge to take action immediately, even if it offers only a partial solution in the short run.

C. Health Care Providers

Insurance alone will not result in easy access to care for Merced County children. There must be sufficient numbers of health care providers throughout the county who will participate in the program. If physicians and hospitals are not available to serve children, a new insurance program will not automatically translate into access to care. This is a challenge as Merced County seeks expanded health insurance for low-income children.

A low ratio of physicians to population has plagued the San Joaquin Valley for years. A study of the physician workforce by the University of California, San Francisco, detailed the significant variation in the number and distribution of physicians across regions of the state (Dower, et al, 2001). According to the study, while California averaged 67.4 primary care physicians per 100,000 population, Merced County was below the average at 46.6. Merced County also compared poorly to the state with regard to physician specialists. California averaged 122.2 specialists per 100,000 population while in contrast, Merced County recorded 48.6. Merced County is also below the statewide averages for dentists, registered nurses and mental health professionals.

Even before thought is given to attracting new providers, the question is how will the current availability of providers be maintained? And what challenges will be brought by Medi-Cal managed care? Federally Qualified Health Centers (FQHCs), a key safety-net provider setting for low-income persons in Merced County, appear to prefer and prosper financially with payment systems in which certain services, such as CHDP, are provided on a fee-for-service basis. However, CHDP would be incorporated into Medi-Cal managed care as well as the expanded children's insurance product. FQHCs have prospered under Medi-Cal managed care in other counties in which they have also actively participated. The extensive history of Medi-Cal managed care in California, dating back to the early 1980s, strongly suggests that a publicly-sponsored plan offers the greatest flexibility in supporting traditional and safety net providers.

D. Funding

Both the California HealthCare Foundation and The California Endowment have recently awarded grants to Merced County to explore the integration of Medi-Cal managed care, a Children's Health Initiative and indigent care. Two additional potential funders include the David and Lucile Packard Foundation, which has indicated willingness to expand beyond its traditional South Bay counties the Blue Shield Foundation which has actively supported insurance programs for low-income children around the state.

The First 5 Commission – Merced County has already funded some outreach, access and support to HCAC and is actively involved in this collaborative process on behalf of children ages 0-5. Most importantly, the First 5 Commission has committed funds in the form of health care premium subsidies on a long-term basis to insure low-income children not eligible for either Medi-Cal or Healthy Families in Merced County.

Notwithstanding the generous financial commitment from Merced's First 5 Commission, fundraising for children 6-18 years will be an ongoing challenge. Other funders must be tapped to obtain premium subsidies for this group of children. The possibility of funding will be explored with Catholic Healthcare West, which operates Mercy Medical Center Merced, and the local health care districts (Bloss Memorial and West Side Community). Local businesses and service clubs will be approached to sponsor children. Lastly, as in other counties which have developed Healthy Kids programs, the Board of Supervisors has also been an important source of funding. While fundraising presents some obvious challenges, a well-conceived, concerted and patient effort must be launched to secure additional financial support.

E. Learning from Predecessors around the State

California counties have been taking affirmative action to address the need for low-income children's health insurance. Since 2000, over a dozen counties have launched success programs, combining a CHI and a gap insurance product. There are many successful predecessors from which Merced County can learn and then adapt to its own needs and circumstances. Already MCHCC has been briefed by the Director of Public Health. A plan that creates a single entry point for outreach, enrollment, utilization and retention is a key to success and Merced County has that system in place already. It will

be challenging to identify a health plan, either commercial or public, that will be willing to do all that is required to introduce a new coverage product for this population, especially given Merced County's limited provider network. Involving the community and securing their "buy-in" is essential. Mathematica Policy Research, Inc. issued a policy brief on its evaluation of Santa Clara's Children's Health Initiative, and their key findings should become part of Merced County's planning: for example, Merced County should expect to increase enrollment in Healthy Families and Medi-Cal while enrolling all children under 300% of poverty in coverage programs, thereby leveraging state and federal funding. Similarly, Merced County's coordinated enrollment process will serve as a foundation of the CHI. The simple and direct enrollment message will make it easier for CAAs to reach more children. Through First 5 California, MCHCC has studied documents from the Institute for Health Policy Solutions that outline the issues and questions needed to make a CHI a viable option for children in Merced County. At the same time, MCHCC and HCAC recognize that Merced County must develop a program that takes the best of what has worked elsewhere and adapt it to the local situation.

F. Major Stakeholders

The major stakeholders, as described earlier, are the participants in the MCHCC and the HCAC. MCHCC serves in the capacity of a CHI Coalition and has formed a Steering Committee specifically to advance the Initiative. Membership has been extended to members from HCAC to join as well as other agencies serving youth and non-English speaking populations. The Steering Committee will recruit members to various working groups, which will have responsibility for hammering out proposals about governance; financing and sustainability, including budget and enrollment projections, premiums and premium assistance; community education; defining the coverage package; and assessing and engaging local providers to expand the existing networks. Importantly, on March 15, 2005, the Board of Supervisors voted to support the development of a Children's Health Initiative and insurance for all children in the county.

12. Conclusions and Recommendations

A. Conclusions

- Too many children lack health insurance in Merced County. This recognition must strongly influence the need to establish a campaign to enroll children in existing public health coverage programs to development of new health insurance product for low-income children who do not qualify for existing public programs.

- Merced County must continue the outreach, enrollment assistance and training activities currently performed by the Healthy Communities Access Project.

- Merced County cannot afford to lose the momentum built by the efforts of the First 5 Commission, the Board of Supervisors, the Healthy Communities Access Project, the CHI Steering Committee and the Children's Summit. This broad support can fashion measures to address the uninsured problem in Merced County now.

- Other California counties have organized successful initiatives to cover low-income uninsured children using intense outreach and enrollment campaigns while collaborating with local Medi-Cal managed care plans. To build on successful experiences elsewhere, Merced County must link its Children's Health Initiative with Medi-Cal managed care, because in the long run, public accountability has been a predictor of responsive operation and successful fundraising.

B. Recommendations

- Continue the aggressive program of outreach and enrollment assistance in existing public health coverage programs to target eligible children who are eligible, but not be enrolled.

- Bolster enrollment assistance efforts with education on appropriate use of health care services and enrollment retention to assure access and continuity of care.

- Even as local planning for Medi-Cal managed care begins, contract with a commercial health plan or with CalKids to provide expanded coverage for low-income children not eligible for public insurance programs. Make it clear to the plan that this arrangement is not a precursor to Medi-Cal managed care in Merced County, but simply a "gap" approach to address the immediate problem.

13. Next Steps

The recommendations must be put into action, if Merced County is going to address the problem of uninsured children in a comprehensive way. With this report in hand, the next steps should be to share its analysis, conclusions and recommendations, detail the necessary organizational requirements, meet with key groups and prepare the blueprint for gathering essential resources. More specifically:

Step One: Discuss this planning and feasibility report with the CHI Steering Committee and the CHI Coalition. Deliberate on conclusions and achieve agreement to move forward.

Step Two: Present this planning and feasibility report to the Merced County Board of Supervisors and to the First 5 Commission with the Steering Committee's recommendations for moving forward.

Step Three: Identify the administrative infrastructure needed to initiate a formal CHI organization, stabilize and sustain HCAP efforts, hire staff to coordinate CHI activities and serve as a link to HCAP and any other outreach and enrollment campaigns.

Step Four: Bring health care providers together for a briefing on CHI and Medi-Cal managed care. Use the opportunity to talk about the potential galvanizing power of a countywide effort in Merced County.

Step Five: Develop a Letter of Interest and release to health plans by October 1, 2005, with responses due by November 1, 2005, to gauge interest in providing a gap coverage product.

Step Six: Develop a fundraising plan and implement by November 1, 2005.

14. Attachments

Attachment I Comparison of Children's Coverage Programs—Summary of Benefits and Cost to Members

Attachment II Overview of Local Children's Coverage Expansions—Selected Counties Only

Attachment III Federal Poverty Level (2005)

Attachment I

Comparison of Children's Coverage Programs' Summary of Benefits and Cost to Members

ATTACHMENT I
Comparison of Children's Coverage Programs in California
Summary Benefits and Costs to Members

	Healthy Families		**CalKids**	**Medi-Cal**	**Generic Healthy Kids**	
	Gross Inc < 250% of FPL		Gross Inc < 250% of FPL	Depends on age; can be up to 200% of FPL	Gross Inc < 300% of FPL	
Services	**Benefit**	**Cost to Member**	**Benefit**	**Cost to Members**	**Benefit**	**Cost to Members**
		Monthly premium is between $4 and $15 for each child up to a maximum of $45 for all children in a family.	$20/child/month premium costs (in Orange and Solano Counties monthly premium cost is $10) . Co-pays range from $5 - $10 at time of service.	**Services** No copays in California. Depending on family income, there may be monthly Share of Cost.	**Services**	Monthly premium is between $4 and $9 for each child up to a maximum of $27 for all children in a family.
HEALTH SERVICES						
Physician Services	• Office visits • Follow-up treatments • Specialist/ consultants • Outpatient diagnostic studies and treatments • Outpatient laboratory and x-ray services • Allergy testing and treatment	• $5 per visit	• Office visits • Follow-up treatments • Specialist/ consultants • Outpatient diagnostic studies and treatments • Outpatient laboratory services • Injectable medications (administered in doctor's office)	• Office visits • Follow-up treatments • Specialist/ consultants • Outpatient diagnostic studies and treatments • Outpatient laboratory and x-ray services • Allergy Testing and Treatment	• Office visits • Follow-up treatments • Specialist/ consultants • Outpatient diagnostic studies and treatments • Outpatient laboratory and x-ray services • Allergy testing and treatment	• $5 per visit • $3 per visit • $5 per visit
Preventive Care	• Periodic health examinations (including well-baby care) • Variety of family planning services • Prenatal care • Vision and hearing testing • Immunizations • Confidential	• No copayment for children (including office visits)	• Allergy testing and treatment (including serum and medication) • Outpatient Services, Same-Day Outpatient Surgery • Outpatient Physical Therapy • Vision and Hearing Services • Immunizations • Routine Physical Exams • Health Education	• Routine physicals and examinations • Vision and hearing examinations • Immunizations • Health education • Outpatient Services, Same-Day Outpatient Surgery • Family planning services, devices and methods • Genetic disease screening	• Periodic health examinations (including well-baby care) • Variety of family planning services • Prenatal care • Vision and hearing testing • Immunizations • Confidential	• No copayment

	Healthy Families		CalKids	Medi-Cal	Generic Healthy Kids	
	Gross Inc < 250% of FPL		Gross Inc < 250% of FPL	Depends on age; can be up to 200% of FPL	Gross Inc < 300% of FPL	
Services	**Benefit**	**Cost to Member**	**Benefit**	**Cost to Members**	**Benefit**	**Cost to Members**
	HIV/AIDS counseling and testing • Pap smear • Health education services			• AIDS testing and counseling	HIV/AIDS counseling and testing • Pap smear Health education services	
24 hour Advice Nurse	• Not covered		• Covered	• Not covered	• Covered	
Prescription Drugs	• 30-34 day supply of brand name or generic drugs, including prescriptions for one cycle of tobacco cessation drugs/year • 90-100 day supply of maintenance drugs • While in the hospital • FDA approved contraceptive drugs and devices	• $5 per prescription • $5 per prescription • No copayment for inpatient drugs • Copayment	• Brand name • Generic • Mail order	• Brand name • Generic • Over the Counter	• 30-34 day supply of brand name or generic drugs, including prescriptions for one cycle of tobacco cessation drugs • 90-100 day supply of maintenance drugs • While in the hospital • FDA approved contraceptive drugs and devices	• $5 per prescription • $5 per prescription • No copayment for inpatient drugs • No copayment for FDA approved contraception
Hospital	• Inpatient care • Outpatient Services	• No copayment	• Covered by Emergency Medi-Cal	• Inpatient care • Outpatient Services • Skilled nursing facility care	• All Inpatient Acute • All Outpatient Services	• No copayment • $5 copayment
Emergency Health Care Services	• 24-hour emergency care for serious medical or psychiatric condition, illness or injury of such severe symptoms that the absence of immediate medical attention can	• $5 per visit unless hospitalized • No coverage will be provided if the services received are not an emergency	• Emergency Care in or out of area • Physician and medical services • ground or air ambulance transportation	• Emergency Care in or out of area • Physician and medical services • Ground or air ambulance transportation ▪ No coverage will be provided if the services received are not an emergency	• 24-hour emergency care for serious medical or psychiatric condition, illness or injury of such severe symptoms that the absence of immediate medical attention	• $5 Copayment • No coverage will be provided if the services received are not an emergency

	Healthy Families		CalKids	Medi-Cal	Generic Healthy Kids	
	Gross Inc < 250% of FPL		Gross Inc < 250% of FPL	Depends on age; can be up to 200% of FPL	Gross Inc < 300% of FPL	
Services	**Benefit**	**Cost to Member**	**Benefit**	**Cost to Members**	**Benefit**	**Cost to Members**
	reasonably expected by a prudent layman to result in any of the following: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part. Emergency care is covered both in and out of the service area and in and out of participating plan facilities. • Emergency ambulance transportation, "911" Service				can reasonably expected by a prudent layman to result in any of the following: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part. Emergency care is covered both in and out of the service area and in and out of participating plan facilities. • Emergency ambulance transportation, "911" Service	
Maternity	• Prenatal and postnatal care, inpatient and newborn nursery care	• No copayment	• Not covered	• Prenatal and postnatal care, inpatient and newborn nursery care	• Prenatal and postnatal care, inpatient and newborn nursery care	• No copayment
Medical Transportation	• Emergency ambulance transportation	• No copayment	• Emergency ground or air ambulance transportation	• Ambulance and other medical transportation only when ordinary public or private conveyance is medically contra-indicated and transportation is required for obtaining needed medical care.	• Emergency ambulance transportation	• No copayment

	Healthy Families		CalKids	Medi-Cal	Generic Healthy Kids	
	Gross Inc < 250% of FPL		Gross Inc < 250% of FPL	Depends on age; can be up to 200% of FPL	Gross Inc < 300% of FPL	
Services	**Benefit**	**Cost to Member**	**Benefit**	**Cost to Members**	**Benefit**	**Cost to Members**
Diagnostic and Therapeutic X-ray and Laboratory Services	• Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on the care of members	• No copayment	• Diagnostic laboratory and radiology services	• Diagnostic laboratory and radiology services	• Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on the care of members	• No copayment
Durable Medical Equipment	• Medical equipment appropriate for use in the home; oxygen and oxygen equipment; insulin pumps and all related necessary supplies	• No copayment	• CCS covers most – remainder could be an added benefit	• Covers wide range with prescription, with prior authorization Alterations or improvements to real property are not covered, except when authorized for home dialysis	• Orthoses, Prostheses, hearing aids, other DME	• No copayment
Mental Health	• Diagnosis and treatment of mental illness. • Outpatient and inpatient services are provided without limit for serious mental illnesses. All non-serious mental illnesses are limited to 20 outpatient and 30 inpatient hospital days	• No copayment for inpatient services • $5 per visit for outpatient services	• Provider Magellan • Limited to 8 Sessions • “Family Assistance Program”	• Mental Health services provided through County Mental Health Department	• Inpatient limited to 30 days per year • Outpatient visits up to 20 per year	• No copayment • $5 copayment

	Healthy Families		CalKids	Medi-Cal	Generic Healthy Kids	
	Gross Inc < 250% of FPL		Gross Inc < 250% of FPL	Depends on age; can be up to 200% of FPL	Gross Inc < 300% of FPL	
Services	**Benefit**	**Cost to Member**	**Benefit**	**Cost to Members**	**Benefit**	**Cost to Members**
Alcohol and Drug Abuse **[Chemical Dependence]**	• *Inpatient:* As medically appropriate to remove toxic substances from the system. • *Outpatient:* 20 visits per benefit year (Some plans may increase the number of visits in a benefit year as medically necessary.)	• No copayment for inpatient services • $5 per visit for outpatient services	• Not covered	• Heroin detox, including inpatient with prior authorization • Individual and group counseling, day care, outpatient drug free counseling, residential treatment	• *Inpatient:* As medically appropriate to remove toxic substances from the system. • *Outpatient:* 20 visits per benefit year (The Plan may increase the number of visits in a benefit year as medically necessary.)	• $5 Copayment • $5 Copayment
Physical, Occupational, Speech Therapy	• Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.	• No copayment for inpatient therapy • $5 per visit for outpatient services	• Most covered by CCS	• Physical therapy evaluation, treatment planning, treatment, instruction, consultation and topical medication, according to Medi-Cal policies • Speech therapy, generally through EPSDT • OT covered with prior authorization	• Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home.	• $5 Copayment
Home Health Care	• Health services provided at home by health care personnel. • Must be prescribed or directed by the attending physician or authorized by plan designee	• No copayment	• Most covered by CCS	• With a written treatment plan reviewed by a physician every 60 days" • Part-time skilled nursing services • Physical, occupational or speech therapy • Medical social services • Home health aide services • Medical supplies other than drugs and biologicals • Medical appliances	• Health services provided at home by health care personnel. • Must be prescribed or directed by the attending physician or authorized by plan designee	• $5 Copayment

	Healthy Families		CalKids	Medi-Cal	Generic Healthy Kids	
	Gross Inc < 250% of FPL		Gross Inc < 250% of FPL	Depends on age; can be up to 200% of FPL	Gross Inc < 300% of FPL	
Services	**Benefit**	**Cost to Member**	**Benefit**	**Cost to Members**	**Benefit**	**Cost to Members**
Skilled Nursing Care	• A licensed Skilled Nursing Facility when Medically Necessary. • Maximum of one hundred (100) days per Benefit Year.	• No copayment	• Most covered by CCS	• Covered, with plan of care that is reviewed at least every 90 days	• A licensed Skilled Nursing Facility when Medically Necessary. Maximum of one hundred (100) days per Benefit Year.	• No copayment
Acupuncture	OPTIONAL • 20 visits per benefit year	• $5 per visit	• Not covered	• 2 visits per month for pain	• 20 visits per benefit year	• $5 per visit
Chiropractic	OPTIONAL • 20 visits per benefit year	• $5 per visit	• Not covered	• 2 visits per month	• 20 visits per benefit year	• $5 per visit
Biofeedback	OPTIONAL • 8 visits per benefit year	• $5 per visit	• Not covered	• Unknown	• 8 visits per year	• $5 per visit
Elective abortion	OPTIONAL • Health plans vary	• No copayment	• Not covered	• Covered as a physician service, regardless of gestational ages of fetus	• NA	• NA
Vision services	• Provided by specialized health plan		• Provided by VSP		• Provided by specialized health plan	
Eye exams	• Once every 12 months	• $5 per exam	• Once every 12 months $10 co-pay	• Covered	• Eye Examination	• $5 Copayment
Prescription Glasses	• Once every 12 months	• $5 per glasses, frames, or lenses	• Lenses/frames $10 co-pay	• Lenses and frames or contacts		• $5 per glasses, frames, or lenses
DENTAL SERVICES	• Provided by specialized health plan		• Provided by SafeGuard	• Provided by specialized health plan	• Provided by specialized health plan	
Preventive Care (Teeth Cleanings, Topical Fluoride)	• Every 6 months	• No copayment	• Covered	• Covered	• Every 6 months	• No copayment
Fillings	• As needed for subscriber children	• No copayment for children	• Covered	• Covered	• Covered	• No copayment

	Healthy Families		CalKids	Medi-Cal	Generic Healthy Kids	
	Gross Inc < 250% of FPL		Gross Inc < 250% of FPL	Depends on age; can be up to 200% of FPL	Gross Inc < 300% of FPL	
Services	**Benefit**	**Cost to Member**	**Benefit**	**Cost to Members**	**Benefit**	**Cost to Members**
Sealants	• As needed only for permanent 1st and 2nd molars	• No copayment	• Covered	• Covered	• As needed only for permanent 1st and 2nd molars	• No copayment
Diagnostic Services	• X-rays (Bitewing, Full-mouth and Panoramic) • Consultations	• No copayment	• Covered	• Covered	• X-rays (Bitewing, Full-mouth and Panoramic) • Consultations	• No copayment
Major Services	• Root canals • Oral surgery • Crowns and bridges • Dentures	• $5 per visit • $5 per visit • $5 per visit • $5 per visit	• Not covered	• Root canals, crowns and bridges require prior authorization • Oral surgery is covered	• Root canals • Oral surgery • Crowns and bridges • Dentures	• Copayments vary
Orthodontia Services	• Provided to members under the age of 21 through the California Children's Services Program (CCS) when condition meets the CCS Program criteria.	• No copayment	• Not covered	• Provided to members under the age of 21 through the California Children's Services Program (CCS) when condition meets the CCS Program criteria.	• Provided to members under the age of 21 through the California Children's Services Program (CCS) when condition meets the CCS Program criteria	• No copayment

* Benefits are provided if the insurance plan determines them to be medically necessary.

** In addition to these benefits, some services are also provided by the California Children's Services (CCS) Program and by County Mental Health Departments. Subscriber children who are under 19 years of age and diagnosed as having a Serious Emotional Disturbance (SED) will receive services from the County Mental Health Department.

<u>Eligibility to No-cost Medi-Cal (FPL Program)</u>:
Under age 1: income ≤ 200% of FPL
Ages 1 through 5: income ≤ 133% of FPL
Ages 6 through 19: income ≤ 100% of FPL

Attachment II

Overview of Local Children's Coverage Expansions
Selected Counties Only

Attachment II
Overview of Local Children's Coverage Expansions
Selected Counties Only

Adapted from Liane Wong, et.al. *Pioneers For Coverage: Local Solutions for Insuring All Children in California*, Institute for Health Policy Solutions, 2004, updated 6/9/05

County, Program and Managed Care Plan	Eligibility and Target Population	Program Financing	Benefits	Cost-Sharing	Start Date and Enrollment
Santa Clara: Healthy Kids http://www.chikids.org/ Plan Administrator: Santa Clara Family Health Plan *Local Initiative*	• 18,000 uninsured children with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• Santa Clara County (Master Tobacco Settlement funds) • City of San Jose (Master Tobacco Settlement funds) • First 5 Santa Clara County • Packard Foundation • SCFHP • CHCF • TCE • Health Trust • Lucile Packard Children's Hospital • El Camino Hospital	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• Monthly premiums range from $4-$6 per child with a maximum of $18/family • Copays: $5 for some services, including office visits and prescriptions	• Start date: January 2001 • Children enrolled as of February 2005: 12,659 (2,611 are 0-5; 10,048 are 6-18) • Enrollment capped for children ages 6-18 with a waiting list of 1,579
San Francisco: Healthy Kids Plan Administrator: San Francisco Health Plan *Local Initiative*	• 5,000 children with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• City and County of San Francisco General Revenue funds • First 5 San Francisco County • First 5 California • TCE	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• Monthly premiums range from $4/child • Copays: $5 for some services, including office visits	• Start date: January 2002 • Children enrolled as of October 2004: 3,982 (808 are 0-5; 3,174 are 6-18)

County, Program and Managed Care Plan	Eligibility and Target Population	Program Financing	Benefits	Cost-Sharing	Start Date and Enrollment
Riverside: Healthy Kids Plan Administrator: Inland Empire Health Plan (IEHP) *Local Initiative*	• 14,000 uninsured children with family income up to 250% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• Riverside County • First 5 Riverside County • IEHP • Riverside Community Health Foundation • First 5 California • TCE • CHCF	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• No premiums but an "enrollment processing fee" of $5 or $20 per year for all children in a family, depending on the network selected • Copays: $5 for office visits, prescriptions, vision exams, frames and lenses • Dental copays: $5/$10	• Start date: September 2002 • Children enrolled as of May 2005: 7,149 (1,699 are 0-5; 5,450 are 6-18) • Enrollment cap is 2,060 (children 0-5) and 5,500 (6-18). There are 1,103 children 6-18 on the waiting list.
San Mateo: Healthy Kids http://www.smcchi.org/ Plan Administrator: Health Plan of San Mateo *County Organized Health System*	• Estimated 5,350 children under age 19 with family income up to 400% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• First 5 San Mateo County • San Mateo County BOS • Sequoia Hospital District • First 5 California • Packard Foundation • Peninsula Health Care District • CHCF • Peninsula Community Foundation • Lucile Packard Foundation for Children's Health • Blue Shield of California Foundation • Kaiser Permanente • San Mateo County Children's Health Fund	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• Premiums are paid quarterly based on family income: $4/month/child if up to 150% FPL; $6/month/child if 150-250% FPL; $12/month/child if 250-300% FPL; $20/month/child if 300-400% FPL. No maximum limits for family premiums • Copays: $5 for office visits and prescriptions; preventive visits are free	• Start date: February 14, 2003 • Children enrolled as of May 2005: 5,675 (923 are 0-5; 4,752 are 6-18)

County, Program and Managed Care Plan	Eligibility and Target Population	Program Financing	Benefits	Cost-Sharing	Start Date and Enrollment
Los Angeles: Healthy Kids http://www.chigla.org Plan Administrator: LA Care *Local Initiative*	• Children under age 19 with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• First 5 LA • LA Care • Blue Shield of California • TCE • UniHealth • Parson's Foundation • California Community Foundation • Kaiser Permanente • First 5 California • CHCF	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• Monthly premiums based on family income: $0 if <133% FPL; $4 if 134-150% FPL; $6 if 151-300% FPL. Maximum of $12/month/family • Copays: $0-5; maximum of $250/year	• Start date: July 1, 2003 • Children enrolled as of April 2005: 39,374 (7,364 are 0-5; 32,010 are 6-18)
San Bernardino Plan Administrator: Inland Empire Health Plan (IEHP) *Local Initiative*	• Estimated 12,000 children under age 19 with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• First 5 San Bernardino County • IEHP • CHCF	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• No premiums but an "enrollment processing fee" of $5 or $20 per year for all children in a family, depending on the network selected • Copays: $5 for office visits, vision exams, frames/lenses and prescriptions, • Dental copays: $5/$10	• Start date: July 23, 2003 • Children enrolled as of May 2005: 2,657 (999 are 0-5; 1,658 are 6-18) • Enrollment cap is 1,850 (children 0-5) and 1,700 (6-18). There is a waiting list of 1,013 for children 6-18
San Joaquin: Healthy Kids Plan Administrator: Health Plan of San Joaquin *Local Initiative*	• Estimated 3,000 children 0-18 with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• HPSJ • First 5 San Joaquin • TCE • CHCF	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• Monthly premiums of $5/child • Copays: $10 for office visits, $20 for emergency room	• Start date: October 1, 2003 • Children enrolled as of April 2005: 1,984 (435 are 0-5; 1,549 are 6-18) • Enrollment cap is 750 for children 0-5 and 1,600 for children 6-18. There is a waiting list of 146 for children 6-18

County, Program and Managed Care Plan	Eligibility and Target Population	Program Financing	Benefits	Cost-Sharing	Start Date and Enrollment
Santa Cruz: Healthy Kids http://www.scchealthykids.org Plan Administrator: Coastal Health Alliance *County Organized Health System*	• Estimated 2,300 children under age 19 with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• First 5 Santa Cruz County • First 5 California • Santa Cruz BOS • Community Foundation of Santa Cruz County • TCE • CHCF • Packard Foundation • Pajaro Valley Health Trust • United Way • Dominican Hospital • Sutter Maternity & Surgery Center • Children's Miracle Network	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• Premiums based on family income: \$12/quarter/child if <100% FPL; \$18/quarter/child if 101-200% FPL; \$36/quarter/child if over 200% FPL. Maximum of \$12/month/family • Copays: \$5 for specialty care; \$0-\$5 for dental; and free for well-care	• Start date: July 1, 2004 • Children enrolled as of March 2005: 1,362 (260 are 0-5; 1,102 are 6-18)
Kern: Healthy Kids Plan Administrator: Health Net *Commercial Plan*	• Estimated 1,200 children ages 0-5 with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• First 5 Kern • First 5 California • TCE • Friends of Mercy Foundation	• Comprehensive medical, dental, vision, prescriptions and mental health benefits	• Monthly premiums of \$4-\$7/child, with a \$27 monthly maximum per family • Will begin enrolling children 6-18 in Fall, 2005	• Start date: March 2005, approximately 100 children 0-5 enrolled • Will begin enrolling children 6-18 in Fall 2005
• ***Planning Counties (in order of projected start date)***					
San Luis Obispo: Healthy Kids Plan Administrator: Santa Barbara Regional Health Authority *County Organized Health System Contract*	• Uninsured children 0-18 with family income up to 300% FPL who are ineligible Medi-Cal or Healthy Families, regardless of immigration status	• First 5 San Luis Obispo County • San Luis Obispo County BOS • CHCF • TCE	• To mirror Healthy Families	• To mirror Healthy Families	• Projected Start Date: July 2005

County, Program and Managed Care Plan	Eligibility and Target Population	Program Financing	Benefits	Cost-Sharing	Start Date and Enrollment
Tulare: Healthy Kids Plan Administrator: Blue Cross *Commercial Plan*	• Estimated 4,168 uninsured children 0-18 with family income up to 300% FPL who do not qualify Medi-Cal or Healthy Families, regardless of immigration status	• First 5 Tulare • Foundation for Medical Care	• To mirror Healthy Families	• Sliding premium of $4-$9 per month/child; maximum of $18/month/family	• Projected Start Date: Fall 2005
Fresno: Healthy Kids Plan Administrator: To be determined	• Estimated 8,530 uninsured children who are ineligible Medi-Cal or Healthy Families	• First 5 Fresno • CHCF • HCAP grant	• To mirror Healthy Families	• To be determined	• Projected Start Date: Fall 2005
Sonoma: Healthy Kids Plan Administrator: Partnership HealthPlan of California *County Organized Health System*	• Estimated 2,700 children ages 0-18 with family income up to 300% FPL who do not qualify for Medi-Cal or Healthy Families • CalKids coverage is for children ages 2-18 with family incomes up to 300% FPL	• First 5 Sonoma County • CHCF • Local hospital consortium • Sonoma County Health Department • St. Joseph's Hospital	• CaliforniaKids transitioning to comprehensive benefits to mirror Healthy Families	• To mirror Healthy Families	• Projected Start Date: January 2006
Solano: Healthy Kids Plan Administrator: Partnership HealthPlan of California *County Organized Health System*	• Children with family income up to 300% FPL who do not qualify for Medi-Cal or Healthy Families • CalKids coverage is for children ages 2-18 with family incomes up to 300% FPL	• First 5 Solano • CHCF	• CaliforniaKids transitioning to comprehensive benefits to mirror Healthy Families	• To mirror Healthy Families	• Projected Start Date: January 2006

Attachment III

Federal Poverty Levels (2005)

Attachment III

2005 Federal Poverty Guidelines

Family Unit of Four (4)

% of Federal Poverty Level	Family Income
100%	$19,350
150%	$29,025
200%	$38,700
250%	$48,375
300%	$58,050