Background Data and Models for Expanding Health Insurance Coverage to Uninsured Children in Santa Clara County

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October 19, 2000

This report was funded by The David and Lucile Packard Foundation. The Packard Foundation commissions reports for public information and consideration. The views expressed are those of the authors and should not be attributed to the Packard Foundation or its trustees.

We would like to extend our appreciation to the individuals who shared their time and insights for this report. Our thanks to Elena Chavez, Robert Crittenden, Bob Diprete, Steve Escoboza, Samira Estilai, Dawn Horner, Michael Koch, Gregory Knoll, Jeffrey Lazenby, Ying-Ying Meng, Manning Pellanda and Steve Wish. We also want to thank Linda Baker, Dana Hughes, Gene Lewit, Marian Mulkey, Ed Neuschler, and Jill Yegian for their review of this document.

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Executive Summary

Children's access to health insurance and health care are important determinants of better health outcomes and readiness to learn. A regular source of care is particularly important for children in assuring that appropriate preventive services are provided, acute and chronic conditions are diagnosed and treated in a timely manner, and that children's development is adequately monitored. Furthermore, children's regular access to preventive services can decrease their need for emergency and specialized services.

New estimates, based on data from 1997 and 1998 (the most recent data available), indicate that there are approximately 71,000 uninsured children in Santa Clara County, with a range between 48,000 and 87,000. Of the total number of uninsured children in the county, 72% are eligible for Medi-Cal or Healthy Families but are not enrolled. There are also approximately 20,000 children who are not eligible for Medi-Cal or Healthy Families due to family incomes that are too high or their immigration status. Of these 20,000 children, 50% or nearly 10,000 are undocumented and therefore ineligible for public health insurance programs.

Efforts to enroll these children in health insurance programs have been hindered by several factors. Even though they remain eligible for Medi-Cal, many children lose Medi-Cal coverage when their parents are discontinued from TANF (Temporary Assistance for Needy Families, formerly AFDC). Low-income families have also been deterred from enrolling their children in a system that is complex and confusing. For families with an immigrant member, fear that a family member might jeopardize his or her immigration status (even when their child is a U.S. citizen) discourages them from applying for public benefits, even though in most cases this fear is unfounded. Immigrant families may also be fearful of government programs in general or unfamiliar with the concept of insurance.

Policymakers and community leaders in Santa Clara County and the City of San Jose have become increasingly concerned about the long-term economic and health consequences associated with a significant population of uninsured children. In recent months, a grassroots campaign led by Working Partnerships USA (WPUSA) and People Acting in Community Together (PACT), developed a Children's Health Initiative to achieve 100% coverage for low-income children in Santa Clara County. This proposal involves pooling city and county tobacco settlement funds and Proposition 10 monies within a non-profit organization, expanding efforts to enroll children in existing programs, and creating a new health insurance source for children ineligible for public and private programs. To date, provisional funding has been committed by the County Board of Supervisors ($3 million per year, subject to renewal); the Children and Families First Commission of Santa Clara County ($2 million per year for three years), contingent on matching funds; and the Santa Clara Family Health Foundation ($1 million for development in year 1). The City of San Jose has instituted a grants process for use of the city's tobacco settlement funds that requires a formal application be submitted and approved to access the city's funds for health insurance for children. City funding decisions will be announced in December 2000. Other partners, including several local, state, and national foundations, have expressed interest in supporting a broader children's health insurance initiative.

As efforts move forward to develop a program to reach the county's uninsured children, this report offers information on a range of approaches with potential to reach the maximum number of children in the county. These models reflect innovative efforts to expand health

insurance coverage for children, though in some cases it is still too early to tell if the programs presented will achieve their enrollment goals. The models discussed include:

- **Partnering City and County Collaborative Efforts with Programs for Children Not Eligible for Healthy Families or Medi-Cal.** This model is currently underway in the City of Los Angeles and involves the establishment of a partnership between the Mayor's Commission for Healthy Kids and the California Kids program to provide subsidized insurance for preventive services, prescription drugs, and dental and vision care to children of families with incomes up to 300% of the federal poverty level. Regardless of the program used to insure children ineligible for public programs, the California Kids / Los Angeles model is a source of proven outreach and enrollment strategies for reaching children who are ineligible for public programs, particularly undocumented children. To date, the program has provided health insurance coverage to over 5,000 children in Los Angeles.

- **Targeting Outreach and Enrollment to Children Already Eligible for Free/Reduced Lunch, WIC, and Food Stamp Programs.** This model, also called Express Lane Eligibility or ELE, accelerates enrollment of uninsured children who are already enrolled in other publicly funded programs such as Women, Infants and Children (WIC) or Free and Reduced Price School Lunch (FRPL). In California, Consumer's Union and the Department of Health Services have successfully assisted school districts throughout California in making referrals to Medi-Cal and Healthy Families through the Free and Reduced Price School Lunch program. As of September 30, this effort, which focused on the fall 2000 return to school, is responsible for over 22,000 referrals. ELE's early success in generating referrals and its linkage with natural entry points for low-income children have highlighted its potential to reach large numbers of children. Several options are under development at the Department of Health Services for how an ELE program would be implemented on a statewide basis.

- **Developing Subsidized Employment-Based Strategies for Coordinated Enrollment in Health Care Coverage.** A subsidized work-based approach provides a way for parents and children to be enrolled in the same health plan (which should make it more likely that children will actually access services because their parents will be more familiar with how their health plan works), and also offers a potentially less expensive alternative to covering children directly through a public program because it leverages available employer contributions. This approach is under implementation in California, Massachusetts, and Oregon.

  In San Diego, Sharp Health Plan and the Alliance Health Care Foundation formed the FOCUS program, a demonstration project to reach low-wage families working for small employers. The FOCUS program subsidizes premiums for small employers and their employees with family incomes below 300% of the federal poverty level. Current enrollment in the program stands at nearly 1,800. In Massachusetts the MassHealth program provides health insurance to low-income families and children using both Medicaid and SCHIP funds. When a family has access to employment-based health insurance that meets certain conditions, the "Family Assistance" portion of MassHealth will pay the premium necessary to enroll the family in the employment-based coverage. The state also operates the Insurance Partnership Program to encourage small employers to provide health insurance to their low-income workers and pay at least half of the cost. Finally, Oregon created the Family Health Insurance Assistance Program (FHIAP), a state-funded voluntary effort that provides a subsidy to help families with incomes under 170% FPL purchase employer-based or individual insurance policies. Due to its reliance on state

resources only, its enrollment has been frozen at about 6,500 people, 2,000 of whom are children. The program has a waiting list of 20,000 people.

- **Consolidating Children's Health Insurance Funding and Developing Seamless Intake Systems.** Although the Kids Get Care proposal for the City of Seattle and King County, Washington is still in the planning and development stage, its vision to eliminate financing as a barrier for children and emphasize a seamless intake system and timely use of preventive services are worthy of serious consideration. The proposed program is structured so that all children are eligible to receive primary and preventive care services, with an eventual phase-in of coverage for inpatient care. It includes creation of a single fund to pay for health care services for children who are not eligible for any public or private health insurance; the ability for parents to choose from a designated group of providers to establish a "medical home" for their child; and the development of Web-based systems to simplify intake and eligibility determination.

The innovative models that provide outreach to and coverage for children eligible for public programs, or promote linkages between programs (such as targeting enrollment through WIC and FRPL) and strategically leverage new and existing resources (such as subsidized employment-based strategies), provide experience that may be useful for Santa Clara County in the near term. In the longer term, other models such as King County's Kids Get Care proposal may be viable. The Kids Get Care model ensures that financing is no longer a barrier for families and that resources are dedicated to creating integrated management information systems, seamless operational structures, and outreach strategies necessary to ensure that all children receive timely and appropriate services. In addition, energy and resources could be focused on partnerships that support and encourage employers by helping them to coordinate and provide affordable insurance options for their employees. Finally, based on the experience of each of these models, it is clear that to achieve 100% coverage of children, public/private partnerships should be forged and sustained to fully support the Children's Health Initiative.

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I. Background and Project Goals

Children's access to health insurance and health care are important determinants of better health outcomes and socioeconomic opportunity. Access to health services is particularly important for children in ensuring that acute and chronic conditions are diagnosed and treated in a timely manner, that their health and cognitive development are adequately monitored, and that preventive services are appropriately provided. These issues are of greater concern for low-income children and families, who by and large are at risk of having poorer health outcomes relative to their more affluent peers.

Over 2 million of California's children are uninsured and are less likely to receive the regular and preventive medical care they need to grow up healthy and ready to learn. Of these 2 million uninsured children, 1.5 million are eligible for but not enrolled in Medi-Cal and Healthy Families, the state's primary children's health insurance programs.[1]

Efforts to enroll these children have been hindered by a number of countervailing factors.[2] The disenrollment of eligible children from Medi-Cal when their parents are discontinued from TANF (Temporary Assistance for Needy Families, formerly AFDC) has significantly increased the number of uninsured children. Low-income families have also been deterred from enrolling their children in a system that is administratively complicated, requires long waiting times for approval, and at times does not treat them in a dignified manner. For immigrant families, fear that a family member might jeopardize his or her immigration status (even when their children are U.S. citizens) discourages them from applying for public benefits, even though in most cases this fear is unfounded. In addition, immigrant families may either be generally fearful of government programs or unfamiliar with the concept of insurance. And, many of the families with uninsured children have language, cultural, and geographic barriers that make enrollment a challenge. While state and countywide efforts have expanded to enroll these children, the aforementioned barriers have resulted in many children remaining uninsured.

Policymakers and community leaders in Santa Clara County and the City of San Jose have become increasingly concerned about the long-term health and economic consequences associated with a significant population of uninsured children. In recent months, a grassroots campaign led by Working Partnerships and People Acting in Community Together developed a proposal to achieve 100% coverage for low-income children in Santa Clara County. This proposal involves pooling city and county tobacco settlement funds and Proposition 10 monies within a non-profit organization, continuing to enroll children in existing programs, and creating a new health insurance source for children ineligible for public and private programs. With the availability of tobacco settlement funds both at the county and city levels for a children's health insurance initiative, an important window of opportunity has been opened for ensuring that future generations are healthy and on the road to leading positive and productive lives. At its June 2000 Board meeting, the Santa Clara County Board of Supervisors approved more than $1.9 million to expand the county's Medi-Cal Outreach Program, and with additional support from the Packard Foundation, is also working toward making the enrollment and eligibility process more family-friendly. The Board of Supervisors also pledged an additional $3 million toward a broader initiative to provide health insurance coverage to all children in the county.

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[1] Brown ER, Ponce N, and Teleki S. "Health Insurance Coverage of Californians," in Schauffler HH, Brown, ER et al, *The State of Health Insurance in California, 1999*, The Health Insurance Policy Program, January 2000.
[2] Several reports are available that describe barriers to enrollment, including The Kaiser Family Foundation's *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment*, September 1998 and The 100% Campaign's *Community Voices* series, Reports 1-4, December 1998 to May 2000.

Two months later the City of San Jose issued grantmaking guidelines for allocation of the city's tobacco settlement funds that include projects to expand health insurance for uninsured children. The Request for Proposals (RFP) was released by the City of San Jose on September 28, and funding decisions will be announced December 2000. Other partners, including several local, state, and national foundations, have expressed interest in funding a broader children's health insurance initiative.

ABOUT THIS REPORT

The goal of this environmental assessment is twofold. First, this document provides data on the status of uninsured children in Santa Clara County and the programs that are currently available for low-income children. Second, it offers a description of current outreach efforts and programmatic models proposed or underway in other locales for expanding health insurance coverage to children and families. These models are presented to the County of Santa Clara, the City of San Jose, other potential funding agencies, and community members for consideration and discussion.

Institute for Health Policy Solutions (IHPS) staff gathered information for this environmental assessment through (1) a review of the relevant literature; (2) meetings with senior researchers at the UCLA Center for Health Policy Research regarding the county's uninsured; and (3) interviews with key stakeholders and health policy experts both within and outside the county. The evaluation of different models was guided in part by successful strategies and proposals underway in California and in other states.

This report begins with an overview of California's health insurance programs for children and data estimates of uninsured children in Santa Clara County. Further discussion is then provided on the challenges that remain in reaching and enrolling the county's uninsured children and the efforts that are currently underway to facilitate enrollment of these children. Finally, several options for coverage expansions from elsewhere in the state and the nation are presented, as well as observations on how these options may inform development and implementation of a countywide children's health insurance initiative.

II. Overview of California's Child Health Insurance Programs

In 1997 Congress ushered in a new era when it established the State Children's Health Insurance Program (SCHIP) and provided funds to states to increase children's access to health insurance. California used SCHIP to expand its Medi-Cal program for older children, and created the Healthy Families Program for children ages 0 to 19 in families with incomes between 100% and 200% of the federal poverty level (FPL). This was followed by a further expansion under the fiscal year 1999–2000 budget act to raise the income threshold for the Healthy Families Program from 200% to 250% FPL. Two private sector initiatives, the California Kids and Kaiser Permanente Cares for Kids Programs, have enrolled children ineligible under the public coverage expansions. As a result, several no-cost or low-cost health insurance programs are available for children in California and are summarized below. A more detailed description of the eligibility criteria, services covered, and costs to families that participate in each program is included as Attachment A.

State-sponsored programs

Medi-Cal. Medi-Cal provides no-cost comprehensive health, dental, and vision coverage for children and pregnant women.[3] Eligibility is determined by children's ages, family size, and family income. The program covers newborns age 0 to 1 in families with incomes up to 200% of the federal poverty level (FPL) (see Attachment B—e.g., $33,600 for a family of four). For ages 1 to 6, the programs covers children in families with incomes up to 133% FPL, and for 6 to 19, up to 100% FPL. This program is available to eligible U.S. citizens, legal permanent residents, and certain other immigrants. Undocumented immigrants qualify for restricted Medi-Cal for pregnancy-related services and emergency conditions only.

Healthy Families. The Healthy Families program provides low-cost health, dental, and vision coverage for children in families with incomes up to 250% of FPL and who are not eligible for no-cost Medi-Cal or other health insurance. Eligibility is determined by children's ages, family size, and family income. Monthly premiums are $4 to $9 per child, with a maximum of $27 per family. The program is available to U.S. citizens, legal permanent residents, and other qualified immigrants under age 19.

Children's Health and Disability Prevention Program (CHDP). CHDP is a preventive health care program that provides free health check-ups for children ages 0 to 19 in families with incomes up to 200% FPL, children ages 0 to 21 receiving Medi-Cal, and children on Head Start to help identify health problems and link them with treatment, education, and support services. Applicants are not asked to provide Social Security numbers or immigration status information.

Access to Infants and Mothers (AIM). The AIM program provides prenatal and health care services for uninsured pregnant women and their newborns up to age 2. To qualify, women must be less than 30 weeks pregnant, have no maternity insurance, and have family incomes between 200% and 300% FPL.

California Children's Services (CCS). CCS provides medically necessary care to low-income children with serious medical problems, such as acute and chronic illnesses, genetic diseases, and congenital defects. To be eligible for the program, children must be under 21 and have an adjusted gross family income less than $40,000 or projected out-of-pocket medical costs greater than 20% of family income.

Private programs

CaliforniaKids (CalKids). Launched in 1992, the CalKids program offers an outpatient-only benefit package that also includes vision, dental, and mental health care for children ages 2 to 18 in families with incomes up to 250% FPL who are not eligible for Healthy Families or Medi-Cal. No inpatient services, such as hospitalizations or major surgery, are covered. Families pay $5 to $35 per child per month (based on income) and $5 to $15 co-payments for services. Families are not required to provide Social Security numbers or immigration status information.

Kaiser Permanente Cares for Kids Child Health Plan. The Child Health Plan provides low-cost insurance to children under 19 with family incomes between 250% to 300% FPL and who do

[3] Families whose income is higher than the allowable limits for no-cost Medi-Cal for children will have a share of cost (similar to a monthly deductible) based on their income and family size.

not qualify for Medi-Cal or Healthy Families. The Child Health Plan will also cover siblings of children eligible for the program.

III. Estimates of Uninsured Children in Santa Clara County

For the years 1997 and 1998 (the most recent data available), the UCLA Center for Health Policy Research found that the average uninsured rate for Santa Clara County's children was 14.8% or approximately 71,000 uninsured children, with a range between 48,000 and 87,000.[4] Approximately 80% of these uninsured children have working parents, many of whom do not receive employment-based health insurance or cannot afford such coverage for their dependents.[5]

Table 1. Estimated Percentage and Number of Uninsured Children, Ages 0-18, Santa Clara County

Source	Total Population of Children	Uninsured Rate	Range of Uninsured Rate	Estimated Number of Uninsured Children
March 1998 and 1999 Current Population Surveys	482,492	14.8%	10 to 18%	71,000 [a] Range between 48,000 and 87,000 [b]

Source: Analyses conducted by the UCLA Center for Health Policy Research on the March 1998 and 1999 Current Population Surveys.

[a] The uninsured rate was applied to California State Department of Finance population projections to estimate the number of uninsured children.
[b] The reported rates and numbers of uninsured children are estimates. The true rates and numbers are likely to fall within a 95% confidence interval. All numbers are rounded to the nearest 1,000.

Of the total number of uninsured children in Santa Clara County, 72% (or roughly 51,000 children) are eligible for Medi-Cal or Healthy Families but are not enrolled (Table 2). There are also approximately 20,000 children who are not eligible for Medi-Cal or Healthy Families due to family income or immigration status. It is estimated that 50%, or nearly 10,000, of these children are undocumented.[6]

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[4] The March 1998 and 1999 Current Population Surveys are the most currently available data to derive estimated uninsured rates by county. Two-year estimates were used since they are more precise than single-year estimates.
[5] This percentage is based on an average of state and county figures published in the Schauffler and Brown report on *The State of Health Insurance in California, 1999*, January 2000.
[6] This percentage is based on statewide figures published in the Schauffler and Brown report on *The State of Health Insurance in California, 1999*, January 2000.

Table 2. Estimated Rate and Number of Uninsured Children By Eligibility Status, Ages 0–18, Santa Clara County

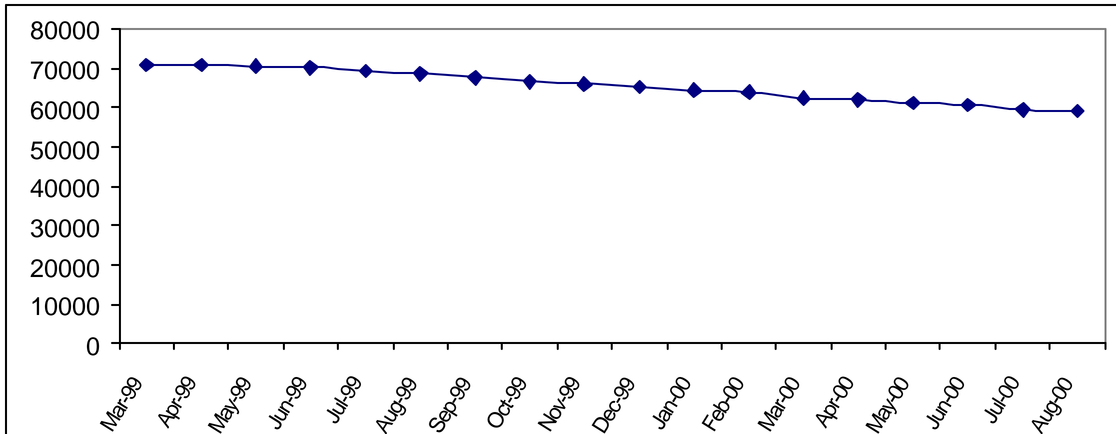
	Rate	Number (Total Uninsured x Rate)
Medi-Cal and Healthy Families eligible	72% [a]	51,000
Children in families with incomes above 250% FPL and undocumented children	28%	20,000

Source: The estimated eligibility and uninsured rates are based on analyses by the UCLA Center for Health Policy Research of the March 1999 Current Population Survey.

[a] The post-November 1999 eligibility criteria for Medi-Cal and Healthy Families Program (HFP) were used. Eligibility rates are calculated by region due to the consideration of sample size. These estimates were derived by applying the Greater Bay Area regional breakdown (Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma) to the estimated number of uninsured in Santa Clara County.

Santa Clara County has experienced a significant decline in the number of children enrolled in Medi-Cal (Table 3). Between March 1999 and August 2000, the number of children enrolled in Medi-Cal in Santa Clara County decreased by 11,723.[7] This decline in enrollment is occurring throughout the nation, for a number of possible reasons. As families leave cash assistance for employment, their children may gain coverage in Healthy Families or through their employer. In addition, as families leave cash assistance, procedural problems may result in their children losing Medi-Cal benefits even though they are still eligible, resulting in the children becoming uninsured.

Table 3. Children (Ages 0-18) Enrolled in Medi-Cal, Santa Clara County, March 1999–August 2000

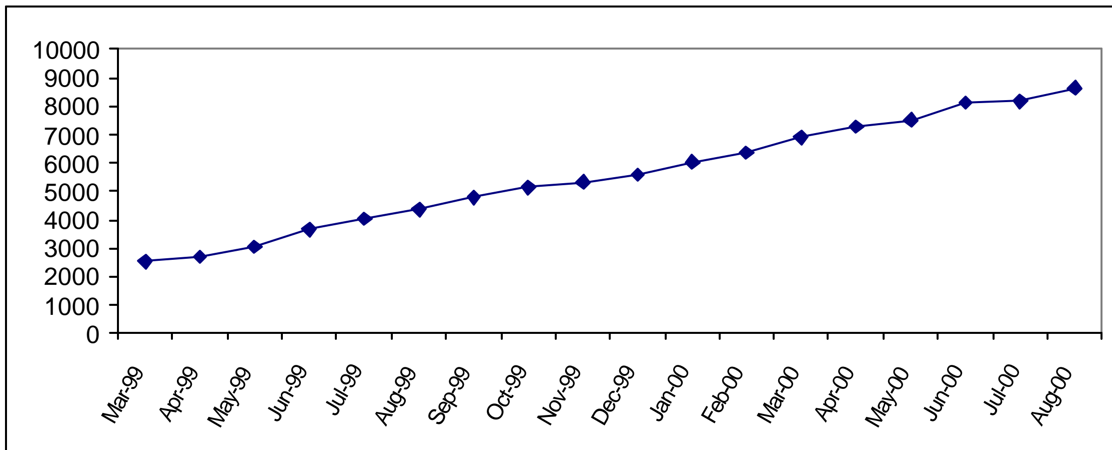


Source: Santa Clara Social Services Agency, Office of Planning and Evaluation, September 2000.

[7] Analysis conducted by Santa Clara Social Services Agency, Office of Planning and Evaluation, September 2000.

However, some of the children no longer eligible for Medi-Cal qualify for programs with higher income eligibility criteria. County enrollments in Healthy Families have increased by 6,094 since March 1999 and enrollment remains open for this program (Table 4). On the other hand, the number of children enrolled in California Kids remains comparatively small due to limits in program financing (Table 5). The Kaiser Permanente Cares for Kids Child Health Plan has also witnessed low enrollment because of its narrower eligibility criteria (between 250% and 300% FPL) and a target group more likely to have access to employer-based coverage. Overall the number of child enrollees in each program continues to fluctuate as state, county, and organizational policies change.

Table 4. Children (Ages 0-18) Enrolled in the Healthy Families Program, Santa Clara County, March 1999–August 2000



Source: Managed Risk Medical Insurance Board, August 2000.

Table 5. Children (Ages 0-18) Enrolled in Selected Health Insurance Programs, Santa Clara County, August 2000

	Current Enrollments
Medi-Cal	58,995[a]
Healthy Families	8,638[b]
California Kids Program	442[c]
Kaiser Permanente Cares for Kids	53[d]

[a] Monthly Medi-Cal enrollments reported by the Santa Clara Social Services Agency, Office of Planning and Evaluation. This figure does not include children who receive Medi-Cal through Supplemental Security Income (SSI), August 2000.
[b] Healthy Families enrollment data are based on the HFP Enrollment report published on August 30, 2000 at http://www.mrmib.gov/hfp/hfreports.html.
[c] The California Kids Program, August 2000.
[d] Kaiser Permanente Cares for Kids Program, August 2000.

It should be noted that some portion of the estimated 71,000 uninsured children in 1998 (see Table 1) have since enrolled in programs and are included in the current enrollments reported in Table 5. However, it is not clear to what extent the number of children that enrolled in other programs has been offset by Medi-Cal disenrollments between 1998 and 2000.

At the time this report was published, data was only available on the total uninsured population in the City of San Jose. According to 1997 data published by the Commonwealth Fund, the average uninsured rate for San Jose was 16.3%.[8] Among San Jose families with incomes below 250% of the federal poverty level, 33% were uninsured. For these families with lower rates of coverage, their ability to access care was limited: nearly one-third were without a usual source of care, and two-thirds had not seen a doctor in the last 12 months.

The Packard Foundation is currently working with the Urban Institute and the UCLA Center for Health Policy Research to provide more precise estimates of the number and characteristics of uninsured children in the county and city. These new estimates will available in coming months.

Challenges to Address

A number of challenges remain in reaching and enrolling the county's uninsured children, and these have been raised by health policy experts and advocates as well as highlighted in several published reports. The most common challenges are:

Complexity of Public Insurance Programs. The number of programs available, each with separate criteria and enrollment procedures, provides a significant barrier for families. In many cases, families with multiple children are faced with having to negotiate several programs as each child may qualify for a different program. Families' concerns with Medi-Cal have generally focused on their negative experiences with the welfare office and/or complicated paperwork. Another common concern is the substantial amount of time and resources it can take to ensure that a child becomes enrolled, including tracking the application through the process and following up on additional documentation requests.

Immigrant Fears Still Exist. The fear of retaliation from the Immigration and Naturalization Service (INS) remains a prevalent barrier to enrollment among immigrant families.[9] Immigrant families perceive more barriers in the enrollment process than non-immigrant families, even though their U.S. born children are eligible for public assistance. While some agencies have provided information to their clients about the May 1999 public charge clarification issued by the INS,[10] this information has not been consistently communicated and reinforced with all parties that advise this diverse community. In addition, many immigrant families whose children are eligible for public assistance, including health insurance, do not seek such assistance for fear of repercussions on the immigration status of another family member or their

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[8] The Commonwealth Fund. *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities*. E. Richard Brown, Roberta Wyn, and Stephanie Teleki., UCLA Center for Health Policy Research, August 2000.
[9] Immigrant families are families with at least one immigrant member.
[10] Public charge is a test administered by the INS and the State Department through its consulates abroad to determine whether immigrants seeking to become legal permanent residents are likely to rely on government assistance (as the primary support for their family). The new guidance clarifies that receiving health care benefits will not affect immigration status (except for long-term care benefits).

ability to sponsor an immediate relative. This fear of immigration consequences is even prevalent among legal permanent residents who want to become U.S. citizens and erroneously believe that applying for non-cash public assistance may affect their naturalization process. Families also may choose not to enroll their children when some but not all of their children qualify for programs.

On July 1, 2000, the County Social Services Agency began fingerprinting CalWORKS, Medi-Cal, and Food Stamp recipients as a requirement of federal law. This requirement may reinforce concerns of potential applicants that information collected for enrollment in these programs will be shared with the INS. Furthermore, fingerprinting is typically associated with the criminal justice system.

Resource and Systems Limitations. Parents typically learn of program availability and criteria through community institutions or by accessing their local welfare office. While some county agencies recognize the importance of children's access to medical care, there are others that perceive the capacity of county agencies to enroll children in available health insurance programs as limited because of overburdened staff and limited financial resources. In addition, spending time with families helping them understand ambiguous rules and policies, filling out complex forms, and collecting what many families perceive to be personal information is a significant task. The lack of funding to support the infrastructure necessary to fulfill this role undermines agencies' ability to carry out multiple functions effectively.

In general, it has proven very difficult to simplify a program operated by the county welfare bureaucracy. Eligibility workers also require ongoing training regarding policy and program changes. Likewise, significant funding is needed to update and maintain management information and computerized eligibility systems.

IV. Current Efforts to Reach the County's Uninsured

Since 1998, Santa Clara County has received outreach and enrollment support through a variety of state and local funding agencies. A majority of the dollars were from State Medi-Cal Outreach and 1931(b) Enhancement funds, Medi-Cal Administrative Activities matching funds, and private foundation support, and were further augmented by County General Fund allocations. County and community clinics, along with many community-based organizations, also provided direct and in-kind contributions toward an array of outreach and enrollment activities. While some individual agencies have developed and implemented their own approaches, the county plays a central role in the Medi-Cal/Healthy Families Outreach, Enrollment and Retention network (it recently committed nearly $2 million to the outreach program), and works with other non-county health care providers and community-based agencies to coordinate outreach and enrollment activities. The list below represents many of the outreach and enrollment efforts in the county, but is not meant to be exhaustive.

The County Network and County Agencies

The **Medi-Cal/Healthy Families Outreach, Enrollment and Retention Network** is a county collaborative effort designed to improve the process for Medi-Cal eligibility determination and implement innovative outreach, enrollment, and retention activities for the Medi-Cal and Healthy Families Programs, as well as the other available programs for children. The network is led by the Santa Clara Valley Health and Hospital System, the Social Services Agency, and the Community Health Partnership, and includes the Santa Clara Family Health Plan, Valley

Health Plan, Public Health Department, Social Services Agency, Valley Medical Center, Valley Community Outreach Services, Alum Rock Union Elementary School District, Working Partnerships USA, the Health Trust, and the Packard Foundation. With funding from the county, the California Department of Health Services, and the Packard Foundation, members of the network have increased their outreach capacity by 30 community health workers and 9 administrative staff. The community health workers are currently located at several county sites and clinics to provide one-on-one enrollment assistance, as well as coordinate activities between public health agencies (e.g., Refugee Services, Family Planning, and WIC). Other workers conduct street and venue-specific outreach activities. The network aims to enroll 7,350 new children and their parents in Medi-Cal, Healthy Families, and other programs, and retain at least 87% of children who are still eligible for their insurance program for a year.

The **Santa Clara County Social Services Agency (SCCSSA)** is the lead entity for eligibility determination and enrollment of children and families in Medi-Cal, Transitional Medi-Cal, and CalWORKs. Families who apply for Medi-Cal usually visit the agency at least once to meet with SSA eligibility staff. SSA workers are also out-stationed in various locations throughout the county. These on- and off-site eligibility workers have the primary responsibility for managing the enrollment process from intake to actual eligibility determination.

The **Santa Clara Valley Health and Hospital System (SCVHHS)** provides medical services and administers public programs for the health of the county's residents. The Health System consists of the Valley Medical Center, Public Health Department, Department of Mental Health, Department of Alcohol and Drug Services, Managed Care, and Ambulatory and Community Health Services (ACHS). Current projects to enroll and retain children and families in low- and no-cost health insurance programs (including Medi-Cal/Healthy Families outreach, enrollment, and retention activities) are organized under ACHS, which is a network of freestanding health clinics located throughout the county. Projects have generally focused on outreach, enrollment, and retention through community health centers and schools. SCVHHS' outreach activities are coordinated through **Valley Community Outreach Services** (VCOS), a separate county-funded program that conducts outreach and benefits counseling through community health clinics, day care centers, faith-based organizations, and schools, as well as door-to-door outreach in the San Jose, Morgan Hill, and Gilroy areas. Among their core enrollment activities, VCOS educates families about program benefits, offers social support services and financial counseling, and refers clients to county eligibility workers.

The Local Initiative and Commercial Health Plans

As a Medi-Cal Two-Plan Model county, Santa Clara County has designated the **Santa Clara Family Health Plan** (the publicly-sponsored local initiative) and **Blue Cross of California** (the commercial plan) to provide services to its Medi-Cal managed care members. Santa Clara Family Health Plan offers an array of provider options to its members, and has its own Outreach Department that coordinates with efforts led by the County network, Valley Community Outreach Services, and the Alum Rock School District. Blue Cross also maintains an active outreach presence in the county, and both health plans are designated as Healthy Families providers.

School Districts

The **Alum Rock Union Elementary School District (ARUESD)** is located in San Jose's east side, serving more than 16,000 students in pre-kindergarten through eighth grades. The district

serves a diverse student body in which Latinos represent 66%, Asians 21%, Whites 7%, African Americans 3%, and Native Americans 1% of the student population. ARUESD is classified as a low-income school district because more than 75% of the district's population live at or below FPL and therefore qualify for the free and reduced school lunch program and low-cost health insurance coverage. During the past year, Alum Rock has organized mass enrollment fairs—where families come to school on a Saturday to get assistance with enrolling their children in health insurance—and has used the school lunch program to promote the availability of health insurance programs. As a result of these efforts, the district has successfully enrolled over 1,500 children since the enrollment fairs were first launched. Alum Rock participates in the Consumers Union Healthy Kids, Healthy Schools project as one of four pilot sites that are working on developing models of school-based enrollment in California.

Community Partnerships and Organizations

The Community Health Partnership is a collaboration of nine member agencies, including community-based and government primary care organizations. The Partnership works with the Ambulatory Care Services Division of SCVHHS and the Social Services Agency in the Outreach, Enrollment and Retention Network to coordinate enrollment and retention of children in health insurance programs in the county.

People Acting in Community Together (PACT) is a grassroots advocacy group based in numerous faith-based organizations and congregations in Santa Clara County. The organization became involved in health care issues when Alexian Brothers Hospital was sold to Columbia/HCA, and PACT received substantial funding for direct health care for the poor. PACT has found through extensive surveying that the lack of health insurance coverage is a major concern for its constituents. Consequently, the organization has partnered with Working Partnerships toward the goal of 100% coverage for children in Santa Clara County.

Working Partnerships USA (WPUSA) is a research and policy institute affiliated with the South Bay AFL-CIO Labor Council. WPUSA also provides a variety of services to temporary workers, including employment training, job placement, and benefits coordination. Working Partnerships is working with PACT as part of a broader coalition to insure 100% coverage of low-income children in Santa Clara County.

Funding Agencies and Foundations

The **Health Trust** is a non-profit public charity focused on health and wellness activities in Santa Clara Valley. In the last eighteen months, the Trust created the Family Health Insurance Project to increase access to health care for children and pregnant women by assisting them to enroll in available low-cost and no-cost health insurance programs. The Trust employs a variety of outreach and training strategies that involve school-linked clinics, employers, and agencies that employ temporary workers. The Project has confirmed enrollment of approximately 2,000 children and pregnant women in subsidized health insurance programs. In addition, Project staff have trained or coordinated the training of certified application assistants throughout Santa Clara County.

The David and Lucile Packard Foundation has provided support toward several outreach and enrollment efforts in the county. In 1998, the Foundation provided funding to the Santa Clara Valley Health and Hospital System to coordinate outreach and enrollment efforts in the county. More recently, in July 2000, it provided grants to SCVHHS, the Community Health Partnership,

and the Alum Rock Union Elementary School District to support coordination and implementation of the County Medi-Cal/Healthy Families Network, which works to enroll children in any available health plan and to make the system easier for families to navigate. At the state level, the Foundation provides substantial funding to the Consumer's Union for its Healthy Kids, Healthy Schools project. This project focuses on assisting schools in enrolling children in no- and low-cost health insurance programs by providing (1) technical assistance to school districts; (2) coordination and monitoring of outreach projects that facilitate connections among schools, state and county agencies, and community organizations; and (3) documentation and dissemination of model outreach programs to other school districts. The Foundation also supports the School Health Connections office in the California Department of Health Services, which provides technical assistance to statewide school-related agencies on school-based enrollment activities.

V. Models for Expanding Health Insurance Coverage for Children

In the process of interviewing stakeholders both within and outside California, several innovative proposals and models for health insurance expansions to children and families came to light. The models presented are grouped conceptually, and should be viewed as potentially complementary rather than mutually exclusive.

A. Partnering City and County Collaborative Efforts with Programs for Children Not Eligible for Healthy Families or Medi-Cal

This model offers proven outreach and enrollment strategies for reaching children who are ineligible for public programs, particularly undocumented children.

1. Los Angeles. In 1997, Los Angeles Mayor Richard Riordan created the Riordan Commission for Healthy Kids. This commission was charged with providing subsidized health care coverage to children of families with incomes up to 300% of the federal poverty level, including undocumented children. Gary Mendoza, former Commissioner of the Department of Corporations, chairs the commission in collaboration with the Los Angeles Department of Health Services, the Office of the Mayor, the City of Los Angeles Commission for Children, Youth and Their Families, Children's Health Access and Medi-Cal Program (CHAMP), and other community-based coalitions.

The program was designed to reach two groups of children. The first group comprises uninsured children who are ineligible for public coverage due to immigration status. No premiums are required for these children, although a nominal co-payment is required at the time service is provided. The second group comprises uninsured children who are ineligible for public coverage due to household income. These children pay an application fee and a monthly amount that is a percentage of the full premium cost.

The commission established a partnership with the CaliforniaKids program to provide a benefit package to program participants that includes preventive and primary outpatient services, including prescription drugs, dental, and vision care. The program does not provide inpatient care services, and instead works with other public programs to coordinate care for participants with chronic or severe illnesses, thus keeping the premium costs to $400 per child per year.

CalKids employs outreach strategies at various levels and in overlapping ways, including community and one-on-one strategies. CalKids staff coordinates with the Commission for

Children, Youth and Families, CHAMP, and other city-appointed organizations to reach many certified application assistants in the city. In addition, CalKids leverages existing city resources by jointly sponsoring health fairs and mass enrollment events through the Commission for Children, Youth and Families' neighborhood networks program.

The California HealthCare Foundation provided $1.5 million over two years to subsidize premiums for approximately 4,000 to 7,000 children depending on their length of enrollment and eligibility status. Enrollment began in January 1999, and more than 5,000 children in Los Angeles are enrolled in the program to date.

Contacts: ***Samira Estilai, Senior Policy Analyst, Office of the Mayor, (213) 847-8516 or Michael Koch, Executive Director, California Kids Program, (818) 461-1406***

Assessment of the City of Los Angeles Partnership with CaliforniaKids Approach

Advantages:

- This initiative builds from an established program. CalKids has the expertise and systems in place to reach and enroll undocumented children, thereby reducing the start-up time for enrolling children (enrollments began within three months of launching the program). The Mayor's Commission provided a means through which CalKids could coordinate with other city programs, such as the Commission on Children, Youth and Families. The city's resources for outreach were leveraged in a systematic and coordinated manner.
- The CalKids Program has been successful in using application systems and processes that reinforce the image of the program as accessible and user-friendly. The program has carefully crafted a private identity, thereby generating less stigma with clients than if attached to a county government agency. This population has historically been hard to reach because of their mobility and their general distrust of public programs.
- Since CalKids is a statewide program, there is some degree of health insurance coverage portability for families who move within the state.

Challenges:

- The benefit package currently offered through CalKids is for outpatient services only with dental, vision, and pharmacy included. Inpatient services are not included in the cost estimates. However, the CalKids program experience has been that very few children actually require inpatient coverage.
- This program may not be sustainable in the long-term as it is dependent on a finite amount of foundation funding to subsidize the premiums.
- The current application fee of $25 is a financial barrier for some families.
- In Santa Clara County, the current provider network that CaliforniaKids contracts with is limited to county-sponsored clinics, and families who are fearful of governmental entities may refuse to access these clinics. In order to reach these families, the provider network should include community health centers and other providers that service specific ethnic communities.

B. Targeting Outreach and Enrollment of Children Already Eligible for Food Stamps, WIC, and Free and Reduced School Lunch Programs

This model works to accelerate enrollment of uninsured children who are already enrolled in other public programs, and uses natural points of contact with families (such as schools).

1. California. Express Lane Eligibility (ELE) is an approach that accelerates enrollment of uninsured children already enrolled in other publicly funded programs with similar income eligibility criteria, such as WIC or Free and Reduced Price School Lunch.[11] During the 2000 legislative session, legislation was passed authorizing implementation of Express Lane Eligibility through the Food Stamp, WIC and Free and Reduced School Lunch programs. Language to support Express Lane Eligibility will be included in the budget for FY 2001–02 and potentially in a state 1115 waiver application. Currently, options are being developed at the California Department of Health Services for how an ELE program would be implemented on a statewide basis.

Current options under consideration include:

a. Targeting outreach to children in income-comparable programs;
b. Streamlining the enrollment of children already connected to income-comparable public programs; and
c. Performing "adjunctive eligibility," where children already enrolled in income-comparable public programs are automatically deemed eligible for Medi-Cal and Healthy Families.

The first option can be implemented in various ways at the county level with the least amount of state and federal administrative red tape. For example, a county Department of Public Social Services agency can send notices of potential Medi-Cal eligibility to food stamp households with children who are not enrolled in TANF. To accomplish this, Food Stamp case files with children would be compared against Medi-Cal enrollments to facilitate eligibility determination. This is feasible since Food Stamps, TANF, and Medi-Cal are all administered by DPSS.

School districts can also expand their outreach programs to children who are eligible for the Free and Reduced School Lunch program. This can be accomplished through education, referrals, and on-site enrollment assistance. In California, Consumer's Union and the School Health Connections office at the Department of Health Services have assisted school districts in sending out, along with the application for Free and Reduced Price Lunch, "request for information" sheets about health insurance. These efforts, which focus on the return to school in the fall, have been very successful: as of September 30, 2000, schools are again the most common source of referrals for Healthy Families and Medi-Cal in the state. Alum Rock School District in San Jose is a pioneer in this endeavor and has facilitated enrollments by linking with the school lunch program. In their first year, Alum Rock generated 2,000 referrals from their school lunch outreach program.

Women, Infants and Children (WIC) is another natural entry point for identifying and enrolling children. Fifty percent of all infants and children enrolled in California's WIC program do not have Medi-Cal coverage, although virtually all of them are eligible. Requirements under federal WIC regulations also stipulate that WIC programs screen for Medi-Cal eligibility. According to The Children's Partnership, with additional funding, support a spectrum of strategies and tools could increase WIC's involvement in health insurance outreach and

[11] The Children's Partnership. *Express Lane Eligibility: How to Enroll Large Groups of Uninsured Children in Medicaid and CHIP*, December 1999. Information for this section comes from research and analyses conducted by The Children's Partnership.

enrollment.[12] A majority of these strategies require state level action, and the Department of Health Services has begun to implement strategies to reach WIC-enrolled children. However, there is still room at the county level for enhanced innovation and simplification, such as providing training about the current health insurance system to WIC staff and setting up an automatic referral system for sending interested families' contact information directly to Medi-Cal eligibility workers or Certified Application Assistants for follow-up. Finally, through a waiver with the federal Health Care Financing Administration, the state could develop a system for granting automatic Medi-Cal/Healthy Families eligibility to those children already enrolled in the Food Stamp program or Supplemental Security Income (SSI) benefits. This strategy, which requires the most coordination among federal and state agencies, has the most potential for reaching large numbers of eligible children.

Contacts: ***Dawn Horner, Associate Director, The Children's Partnership, (310) 260-1220 or access their Web site at www.childrenspartnership.org***

Elena Chavez, Healthy Kids Healthy Schools Program Coordinator, Consumers Union, (415) 431-6747 x106 or access their Web site at www.healthykidsproject.org

2. Washington State. Washington State's Department of Social Services, in partnership with the state's Office of the Superintendent of Public Instruction and the Children's Alliance, has created two referral programs to reach Medicaid-eligible children through the Free and Reduced Meal Program. The first is a pilot program involving the implementation of a Multi-Use referral form that allows families to request information on free medical coverage for their children on the School Lunch Program application. This information is then transferred to health program staff for follow-up with the families for further application assistance. In the first three months of the program, 1,045 eligible families were reached through the program, of which 319 returned the application. Of the 319 who returned the application, 161 children were enrolled in either Medi-Cal or CHIP. The state is currently in its second year of implementation with 15 pilot sites across the state. However, there have been fewer eligible applicants than expected due to problems with the language used on the referral form (72% of the total referrals were already receiving Medicaid) and parents' concerns about confidentiality. School staff members were also not adequately trained regarding the new procedure.

Since 1995, the state has also instituted a Medicaid Outreach and Assistance Program in all school districts. Each district has agreed to provide the Medicaid Eligibility Program with families' names and addresses if the family indicates on the regular Free and Reduced Lunch application that they would like a referral to Medicaid. According the Social Services Agency, it appears that the number of referrals received is also closely linked to the amount and quality of training provided to school food service staff. In the five years since its implementation, this program has generated more than 1,000 referrals. The county is working to improve the program by providing partial reimbursement to school districts through Administrative Match Agreements. Washington State is also planning to request an 1115 waiver from HCFA to implement adjunctive Medicaid eligibility for children already enrolled in the Food Stamp program.

[12] The Children's Partnership/California WIC Association. *WIC: A Door to Health Care for California's Children*, July 2000.

<u>*Contact*</u>: ***Manning Pellanda, Department of Health and Social Services, Medical Assistance Administration, (360) 725-1542***

<u>Assessment of the California and Washington State Express Lane Eligibility Approaches</u>

Advantages:

- Express Lane Eligibility targets a natural entry points for families and children, such as schools, and links with other public programs familiar to parents.
- ELE strategies reduce the administrative burden on applicants while streamlining the application process. By addressing these two major barriers, health insurance will be more attractive for eligible families.

Challenges:

- When implementing Express Lane Eligibility strategies, additional work demands will be placed on administering agencies or program staff. Implementation will require sustained collaboration among different program agencies and systems, some of which may not be oriented to coordinating or integrating across different programs.
- In some cases, each public program will have a different way of counting family income, such as allowable income and income deductions. Additional information will be required from the family in cases where there are differences between one program and Medi-Cal or SCHIP, which will prolong the process.
- Similarly, while Medi-Cal and SCHIP restrict eligibility to U.S. citizens and certain "qualified aliens," some public programs do not have this requirement. Additional immigration information may need to be obtained to determine the child's eligibility that may discourage some families from applying to the non-health programs.
- Each program has separate confidentiality and disclosure rules designed to protect a family's privacy. Some programs, like Food Stamps, provide a federally defined policy for sharing information with other public programs. Others may have different confidentiality guidelines at the state or local levels. In these cases, interagency agreements are likely to be required to ensure that such information will be used only for outreach and enrollment purposes.
- Each program has its own income eligibility criteria. ELE may not work well for children in higher income families eligible for subsidized health insurance but not for other programs.

C. Developing Subsidized Employment-Based Strategies for Coordinated Enrollment in Health Care Coverage

One way to encourage coverage of low-income children is to subsidize work-based coverage for the entire family. This approach may reach children whose parents would resist enrolling them directly in a public program. It also provides a way for parents and children to be enrolled in the same health plan, which should make it more likely that children will actually access services because their parents will be more familiar with how their health plan works. Because of the available employer contribution, enrolling families in employment-based coverage may be less expensive than covering the children alone directly through a public program. And, finally, subsidizing work-based coverage encourages rather than undermines continuation of the coverage source through which most children (including a sizeable

proportion of low-income children) currently receive health insurance. Examples of this approach include:

1. San Diego County. Sharp Health Plan is a provider-owned, not-for-profit health plan that offers comprehensive medical and preventive care services in San Diego. The Plan currently covers 90,000 lives, of which 45,000 are Medi-Cal, 30,000 commercial, and 10,000 in Healthy Families. Sharp is a Medi-Cal and AIM provider, a Healthy Families contractor, and is a participant in the Pacific Health Advantage and California Choice programs for small businesses.

In 1997, the San Diego County Board of Supervisors commissioned a study of the county's uninsured. The study found that one in four San Diegans are uninsured, and 80% of the uninsured are in working families. Sharp Health Plan and the Alliance Health Care Foundation agreed to form the FOCUS (Financially Obtainable Coverage for Uninsured San Diegans) program, a two-year, $1.2 million demonstration project to reach low-wage families working for small employers. The California Endowment provided $400,000 to expand the number of participants in the program, with the specific objective of covering children who may be undocumented. Current enrollment in the program stands at nearly 1,800 enrollees and more than 200 small businesses.

Premiums are subsidized by a combination of foundation funds, reduced provider and insurance broker payment rates, and health plan donation of administrative services. These subsidies allow a contribution structure under which employers pay a flat rate per employee, ranging from $24.29 to $48.70 per month across the four coverage tiers. (The employer contributes 30% toward single employee coverage and 15% of the dependent premium.) Employees pay their premiums on a sliding scale, ranging from 1% to 4% of their monthly household income. To participate at the subsidized rates, employees must have incomes below 300% of the federal poverty level. Higher-income employees can also participate, but they and the employer must pay the full cost of the premium (with no foundation subsidy). Several employers have chosen to cover their entire workforce, not just their low-income employees.

Sharp Health Plan is conducting a study with participating employers to assess the extent to which their participation in the FOCUS program affects employee retention, morale, productivity, and rates of absenteeism. The Plan is also collecting data on participant utilization and cost because FOCUS services are paid on a fee-for-service basis. Several months into the program, utilization patterns are similar to those of Sharp's commercial population.

Benefits and Provider Network. The FOCUS program provides a rich package of health benefits to participants and meets Knox-Keene requirements, although it does not cover all of the services available to Sharp's commercial employers.[13] Required copayments include $5 for office visits and urgent care, $5 for generic prescription drugs and $15 for brand-name drugs, and $50 for emergency room services. Hospitalizations are covered at 100%. The Plan contracts with several medical groups, an array of individual physicians, and ten hospitals throughout San Diego County.

Marketing and Employer Participation. Sharp marketed the FOCUS program primarily through a media relations campaign and targeted outreach to small business organizations (e.g.,

[13] The major exclusions are inpatient treatment for mental health and chemical dependency, and aggressive treatment of infertility.

chambers of commerce and economic development councils). The most successful vehicle has been through a single television program titled "The Health Insurance Gap," a one-hour program that included a segment about the FOCUS program and contact information during the closing credits. This program was aired in September 1999, and has since generated a large portion of the small employers enrolled. Enrollment was initially closed in January 2000 and then re-opened once the Plan received additional funding from the California Endowment. Maximum enrollment was again reached in August 2000.

More than 90% of eligible employers who inquire about the FOCUS program enroll, despite the additional requirements of participating in the study portion of the program. Given this response, the required employer contribution levels do not seem to be a problem for these employers. While many small employers say that they cannot afford to contribute to dependent coverage,[14] the FOCUS program's employer contribution levels seem to be affordable.

Contact: ***Jeff Lazenby, Director of Business Development, Sharp Health Plan, (858) 637-6696***

Assessment of the San Diego Approach

Advantages:

- This program has been an effective model for allowing low-wage families with access to employment-based health coverage enroll together in the same health plan. This provides parents with "one-stop shopping" for health insurance and should also improve continuity of care for these families.
- Programs like FOCUS support a public-private partnership model that supports and encourages employers by helping them maintain an environment that enables them to provide affordable insurance options for their employees.
- As a result, several proposals have been presented in San Diego to expand the model to a countywide small employers initiative.

Challenges:

- The FOCUS program is not sustainable under current funding arrangements due to the structuring of contracts with providers and insurance brokers. The concessions of these constituents have allowed the FOCUS premium to be much lower than standard commercial products.
- Health plans should be aware that the small size of eligible businesses and their inexperience with group health coverage may cause administrative costs for this type of program to exceed average administrative costs.

2. **Massachusetts.** Massachusetts' MassHealth program provides health insurance to low-income families and children using both Medicaid and SCHIP funds. When a family has access to employment-based health insurance that meets certain conditions, the Family Assistance portion of MassHealth will pay the premium necessary to enroll the family in the employment-based coverage (i.e., the program pays the worker's share of the premium, while the employer makes its regular contribution). In fact, if a family does have access to appropriate employment-based coverage, they are required to take it (i.e., they do not have the option to enroll in the direct coverage part of MassHealth).

[14] In its commercial, small-employer business, Sharp finds that dependent coverage is frequently declined due to lack of any employer contribution.

The conditions that employment-based coverage must meet to qualify for Premium Assistance are:

- The employer must contribute at least 50% of the cost of family coverage;
- It must be no more costly for the state to buy into the employer-based plan than it would be to cover the eligible individual(s) under the regular MassHealth program; and,
- The plan must provide benefits equivalent to those of the largest commercial HMO in the state.

Several thousand individuals, about 70% of them children, are receiving Premium Assistance to enable them to enroll in employment-based coverage. Usually, the employer continues to deduct the worker's share of the health insurance premium from the worker's paycheck in the usual way; the state then sends a subsidy check directly to the family to cover that cost. When CHIP funds are being used, only previously uninsured children/families can receive subsidies to enroll in available employment-based coverage. However, Medicaid funds can be used to subsidize enrollment of currently insured children and families as well, if they meet the income standards.

MassHealth operates as a section 1115 Medicaid Research and Demonstration Waiver project, which has simplified many of the operational challenges the state would otherwise have to overcome to comply with federal SCHIP rules governing this sort of Premium Assistance program. Massachusetts also operates a related program called the Insurance Partnership program. This program is aimed at encouraging small employers to provide health insurance to their low-income workers and pay at least 50% of the cost. If the employer does so, they receive an "incentive payment" from the state for each low-income employee (i.e., workers with family income less than 200% of the federal poverty level). The incentive payment for full family coverage is $1,000. (Lesser amounts are paid for worker-only, couple, and worker-plus-one-child coverage.).

<u>Contact</u>: ***Patricia Canney, Director of Program Implementation, Massachusetts Division of Medical Assistance, (617) 210-5672***

3. **Oregon.** In 1996, the Oregon legislature created the Family Health Insurance Assistance Program (FHIAP), a voluntary effort to expand employer-based insurance. Under the FHIAP, families with incomes under 170% FPL can obtain a subsidy to help them buy employer-based or individual insurance policies. FHIAP was implemented in 1998 with state-only funding. Due to limited resources, its enrollment has been frozen at about 6,500 people, 2,000 of whom are children. There is a waiting list of 20,000.

Oregon has submitted a SCHIP State Plan amendment, requesting approval of a Premium Assistance program that would be administered by an existing consumer-choice purchasing group for small employers. The amendment is still pending approval from the Health Care Financing Administration (HCFA). HCFA's main areas of concern include (1) the minimum employer contribution requirement (HCFA guidance and draft rules both state that an employer must contribute at least 60% of the cost of family coverage for a state to buy into employer-based coverage under SCHIP, while Oregon is seeking a lower employer contribution level for uninsured, small, predominantly low-wage employers); (2) the Medicaid "screen-and-enroll" requirement (applicants eligible for Medicaid may not be enrolled in SCHIP, even if they refuse to formally apply for Medicaid); and (3) the statutory limits on patient cost-sharing. Oregon is developing approaches to address these HCFA concerns. One possible approach would build

on the existing Medicaid Health Insurance Premium Payment (HIPP) program that supplements private coverage to bring benefits and cost sharing up to Medicaid requirements.

***Contact*: Bob Diprete, Director, Oregon Health Council, (503) 378-2422**

Assessment of the Massachusetts and Oregon Approaches

Advantages:

- State officials believe that many families in the targeted income range (150%–200% FPL) have access to employer-based coverage, and they want to take advantage of private dollars that were available for coverage. They also want to give families that couldn't currently afford their private insurance the option of taking that coverage, rather than requiring them to enroll in a completely separate, public program to receive assistance.
- These states also hope to slow the long-term decline in the private insurance market. Officials have concern that as private insurance becomes more expensive, and more employees decline it when offered, employers would stop offering coverage. This dynamic could cause a long-term shift (populationwide) from private to public sources of coverage. By making it possible for employees to accept private coverage when it is offered, state officials hope to encourage employers to continue to make such coverage available. They view this program as a means of both supporting the private insurance market and covering additional children.
- Finally, the states believe that although SCHIP dollars are for covering children, children are not necessarily best served in an environment that is fully separate from their families. It is important for many families to have the same source of care and the same insurance package for all family members. In addition, by buying into employer-based family coverage, states can often give insurance to parents at no cost to the program (beyond what would have been spent to cover only the child under direct coverage). This is possible because of the employer contributions that are available. In many cases, it can be less expensive for some states to assist the family in buying family coverage through an employer than to buy separate insurance for children through a public program.

Challenges:

- Contacting employers to obtain coverage information and assessing whether that coverage meets established standards is a time-consuming and resource-intensive process, particularly if federal standards must be met because federal Medicaid and/or SCHIP funds are being used.
- Few employment-based plans meet all the federal SCHIP benefit and cost-sharing requirements. Designing and administering "wraparound" coverage to fill in these gaps (as SCHIP requires) is difficult and resource-intensive.
- Officials in Massachusetts and Oregon are interested in maintaining the long-term viability of the private insurance market by making it more affordable. If employees continually decline available coverage because it is too expensive, employers may stop offering it. As a result, when children enrolled in public programs lost eligibility, employer-based insurance would no longer even be offered.

D. Consolidating Children's Health Insurance Funding and Developing Seamless Intake Systems

This model provides a vision for eliminating financing as a barrier to health care for children, featuring a seamless intake system and timely use of preventive services.

1. The City of Seattle, and King County, Washington. A pilot program, called Kids Get Care, is being proposed to cover all children in Seattle and King County. The program *is based on the principle that all children will be automatically covered for preventive health care services*. Partners for the project include: the City of Seattle, Public Health–Seattle and King County, Harborview Medical Center, the King County Health Action Plan, and the Washington Health Foundation. The King County Health Action Plan is a joint partnership of Public Health–Seattle & King County and leaders in the private health care system.

The Kids Get Care (KGC) project offers a new paradigm for children's health care. Children in King County currently receive coverage through Medicaid, Healthy Options, the State's Basic Health Plan, the Children's Health Insurance Program, employer-based health insurance, and low-cost care at public clinics and emergency rooms. However, it is estimated that more than 13,000 children are uninsured and not eligible for public programs. The Kids Get Care proposal approaches the problem from the perspective of assuming that all children have a financing mechanism so that emphasis can be placed on building the systems and operational structures necessary to ensure that these children actually receive services.

The key components of the proposal are to:

a. Develop a fund that will pay for health care services for those children in King County who are not eligible for any public or private health insurance;
b. Declare all children within King County covered for preventive health services, with a phase-in period to develop mechanisms to finance inpatient services for chronically ill children;
c. Create a new outreach message and communications strategy, i.e., "your child needs preventive health services, and these services are available and affordable for all children in King County";
d. Create and coordinate medical homes for children so that providers and services are available for children accessing the health system. An established, long-term relationship with a provider will help assure continuity of care so that all children receive timely and appropriate preventive and screening services;
e. Develop electronic systems that maximize the use of technology to simplify enrollment and eligibility determination. This would enable families, providers, and social service agencies to enroll children in appropriate health programs at many locations—by telephone or through Web-enabled devices in providers' offices, social service agencies, and schools;
f. Lead a partnership among private and public organizations to deliver the message, enroll children, and deliver preventive health services; and
g. Develop an evaluation component to assess the impact of the message and systems developed, assess the effectiveness of the systems developed, and improve these systems to better serve children in the region.

Organizational Structure. The Kids Get Care Initiative is a joint effort of the Washington Health Foundation, the City of Seattle, and King County. Direct oversight of the project will be provided by the Seattle & King County Public Health Departments and the King County Health Action Plan. Since the program's inception, the Action Plan has worked closely with the Washington Health Foundation and Harborview Medical Center. Project operations will be

centralized through the Washington Health Foundation, which has been working in collaboration with the Public Health Department on physician referral, outreach to Medicaid and SCHIP, and eligibility determination.

Financing. While this proposal has received policy support from the City of Seattle and King County officials, private sources are being approached to fund nearly all program expenses for years 1 to 5. Program sponsors anticipate that grant funding will ultimately be replaced by local and state financing. The major cost of the program is for the preventive services benefit for uninsured children not eligible for public insurance and some of the underinsured children with employer-based insurance who are from families with low incomes. It is expected that the majority of uninsured children identified through this project will be eligible for a public program and will have their service costs covered through that program. All efforts will be made to enroll the uninsured and underinsured eligible children in current public programs. The major public programs include Medicaid/Healthy Options (all children in families with incomes under 200% of the federal poverty level) and SCHIP (children in families with incomes between 200% and 250% of FPL).

Health care expenses are projected to climb slowly over the first year, as it is anticipated that it will take some time to fully enroll the subset of children not eligible for other programs. The estimated cost for covering all children in King County is $7.8 million for five years. The cost of the KGC program will be shared with these enrollees through a sliding scale premium similar to those used under the SCHIP program.

Benefits and Provider Network. The proposed benefit package will consist of preventive services similar to the EPSDT program (Medicaid well-child care, Early and Periodic Screening, Diagnosis and Treatment). These services include well-child care, vision and hearing screening, and immunizations. The current SCHIP program is not charging co-payments for preventive services, so this same standard will be used for the preventive services delivered through the KGC program. The average cost per child per year for the preventive services package is $100. The long-term goal is to phase in comprehensive coverage for acute and chronic health conditions as the population is better defined and accurate estimates can be made of the increased costs of these improvements.

Systems Development and Tracking. The King County Health Action Plan has identified the development of improved systems as a top priority toward improving health outcomes for the children of King County. Project partners are exploring options for developing an eligibility system that can be accessed by telephone or other electronic means. Plans are under development to adapt existing enrollment software products to the Washington State environment to ease the enrollment of children in Medicaid, SCHIP, and Kids Get Care. This software will be integrated into Medical Assistance Administration call lines, current referral lines in the community, the new statewide 1-800 contact number, as well as located at key community sites that have contact with low-income children and families. Project partners are also examining the feasibility of developing tracking and monitoring systems to evaluate the effectiveness of the program, provide cost estimates for each population, and assess utilization and health outcomes of participating children.

Marketing and Outreach. The proposed program will coordinate with state and private agencies, foundations, and organizations to develop marketing materials and a strategy to change the message from "you may be eligible for insurance" to "your child needs preventive care and affordable financing is available." Outreach efforts will focus on informing families

that their children need a medical home and that sources of care and financing are available. These activities will dovetail with those already underway through the Campaign for Kids 2001 coalition, current Medicaid outreach agencies, school districts, churches, social service agencies, health departments, and providers.

Contact: ***Robert Crittenden, Chair, Campaign for Kids 2001, (206) 731-6770***

2. San Diego County. Since 1997, San Diego has undergone an extensive planning process to identify and implement options for reducing the 600,000 uninsured in the county, one-sixth of whom are children. As part of this process, the Board of Supervisors commissioned a report on the status of the uninsured and created a separate advisory committee to oversee the development of programmatic options available to the county. This committee, called the Project Management Committee (PMC), hired the Pacific Health Policy Group to develop a set of options for Board approval. In October 1999, the Board committed the entirety of the county's $65 million in tobacco settlement funds to health care. Of the $65 million, $10 to 13 million annually was earmarked for health access expansion programs. Strategies that were ultimately identified by the Project Management Committee were framed within a two-track process for expanding access to health coverage: Track 1 could be implemented on a short-term incremental basis, whereas Track 2, the umbrella approach, requires state and federal section 1115a Medicaid Demonstration waivers.

- Track 1 options focus on strengthening the existing safety net and raising the financial eligibility income limit for County Medical Services (CMS) participants. In July 2000, the CMS eligibility threshold was raised from $600 to $700 per month and the program was expanded to provide coverage to persons with chronic and disabling conditions.

- Track 2 involves the establishment of a "cooperative" as a separate entity to administer various demonstration components. This cooperative would (1) provide a single point of entry for small businesses and the uninsured; (2) combine federal, state, and local funding, with individual and employer contributions; and (3) improve participation in current health insurance programs. The demonstration components of this second track involve all health plans in San Diego that participate in Medi-Cal and Healthy Families, and are designed to move the county toward a seamless health insurance system.

Toward the ultimate goal of a seamless insurance system, the county is planning to integrate its data and tracking systems, as well as facilitate electronic Medi-Cal/Healthy Families application submission and eligibility determination. San Diego is the first pilot site for the California HealthCare Foundation/MRMIB Health-e-Application. The Health-e-App allows counties to electronically submit the combined Medi-Cal/Healthy Families application through any Web-enabled device and provides for "real time" preliminary eligibility determination. If the Health-e-App is successfully piloted in San Diego, it will provide the basis for developing a paperless verification system, speed up the time it takes for eligible applicants to receive health care services, and expand opportunities for off-site enrollment at various natural entry points for families (such as schools, clinics, and physician offices).

Contact: ***Greg Knoll, Chair, Project Management Committee, (619) 471-2620***

Assessment of the King County and San Diego County Approaches

Advantages:

- Both the Washington State and San Diego County proposals seek to provide a simplified and seamless process for families to access health care services. The enrollment process is streamlined and access to care becomes automatic. Both approaches address many of the barriers discussed in the *Challenges to Address* section on page 7 of this report.
- Children are more likely to have continuity of care and provider consistency under both proposals, which should improve health status and reduce costs for preventable illnesses.
- In the long term, the resources currently used for various outreach and enrollment processes will instead be used to facilitate the improvement of children's health. The issue of financing will no longer be a major barrier for children accessing health care.

Challenges:

- For Washington State, the proposed benefit design is only for preventive care—fairly scaled back compared to the Medicaid or Healthy Options benefit package. It is not clear when the phase-in for inpatient services will occur.
- Both proposals require early participation and buy-in from key parties, particularly providers. Realistic projections of cost and viable payment rates to providers for the new benefit package must be made to maintain service availability. Providers must also be willing to work with the new screening/eligibility process and take referrals for the new program.
- Both proposals require significant political and administrative negotiation to seek and obtain 1115a waivers from Health Care Financing Administration and the State Department of Health Services.
- Both proposals require a significant up-front investment for systems development and integration.
- There are concerns that under these proposed programs employers will be less likely to provide health insurance for employees and their dependents. This phenomenon is a potentially budget-breaking issue, and strategies are required to minimize the potential "crowd out" effect.

VI. Conclusion

This is an exciting time for those concerned about guaranteeing all children access to appropriate, affordable health insurance. As the materials in this assessment demonstrate, a number of promising models are being developed to increase insurance coverage for children, but it is too soon to know which will succeed. Nonetheless, the following observations may be helpful to those developing programs to reach Santa Clara County's uninsured children:

- Some of the innovative models that provide outreach to and coverage for children ineligible for public programs or that promote linkages between programs (such as targeting enrollment through WIC and FRPL) provide experience that may be useful for Santa Clara County in the near term. Other, more "outside the box" options that may be viable in the long term ensure that financing is no longer a barrier for families and that resources are dedicated to creating integrated management information systems, seamless operational structures, and outreach strategies necessary to ensure that all children receive timely and appropriate services. These approaches, while certainly more time- and resource-intensive, may hold real promise in moving the county toward the goal of access to health care for all children.

- There is growing interest across California and the nation in developing strategies to reach uninsured children and families through employers and employment-based initiatives. Programs, such as FOCUS, demonstrate that low-income employees and some uninsured small employers can be induced to purchase private health insurance when adequate subsidies are available. Energy and resources in Santa Clara County could be focused on partnerships that support and encourage employers by helping them to coordinate and provide affordable insurance options for their employees.

- A crucial component common across most models is the need for coordinated investment in up-to-date management information systems and enhanced eligibility systems. Of equal importance is the development of tracking and monitoring systems to evaluate program effectiveness, provide cost estimates, and track utilization patterns and health outcomes of the target populations.

- Given the experiences of other models across the nation, it is clear that significant attention should be paid to structuring public/private partnerships and broad-based collaborations under any of these models.

Attachment A: Description of California Health Insurance Programs for Children

Program	Eligibility	Services Covered	Cost to Participate
Medi-Cal	Age 0-1: up to 200% FPL 1-5: up to 133% FPL 6-19: up to 100% FPL 19-21: up to 92% FPL * Child who is a U.S. citizen or legal resident and a California resident. ** Undocumented and certain other immigrants may still receive emergency and pregnancy-related services if a California resident.	Inpatient/outpatient, preventive care, prescription drugs, lab, dental, vision, mental health and substance abuse services.	No cost or share-of-cost, depending on family income.
Healthy Families	Age 0-1: 200-250% FPL 1-5: 133-250% FPL 6-18: 100-250%FPL * Child must not be eligible for no-cost Medi-Cal. ** Child who is a U.S. citizen or legal immigrant (some exceptions granted) and a California resident. *** Without job-based coverage for 3 months prior to applying for the program.	Medical, dental, vision; some mental health and substance abuse services.	Minimum $4 and maximum $27 monthly premium, depending on family income. $5 co-pay on non-preventive services.
CHDP (Child Health and Disability Prevention)	Age 0-19: up to 200% FPL. 0-21: Medi-Cal children in foster care. * Coverage provided for income eligible child regardless of immigration status.	Preventive care exams, medical office visits for hearing test, nutrition, growth/dental assessments, and immunizations. Diagnosis, treatment and support services for conditions found in exams.	No cost.
CCS (California Children's Services)	Medi-Cal no share of cost. Family income must be under $40,000 OR out of pocket expenses exceed 20% of income for qualifying medical conditions.	Specialized medical care and rehabilitation services for children who are disabled or have a serious illness.	Family may have some financial obligation; $25 processing fee.
AIM (Access for Infants and Mothers)	Income 200-300% FPL; pregnant not more than 30 weeks at application time; health insurance has no maternity coverage or maternity deductible is >$500; income too high for no-cost Medi-Cal.	Prenatal visits; hospital delivery; comprehensive health care for the mother through 60 days after pregnancy; full health care coverage for infant up to age 2.	2% of income plus $100 for child's second year. $50 application fee.

Attachment A: Description of California Health Insurance Programs for Children (continued)

Program	Eligibility	Services Covered	Cost
California Kids	Age 2-19 (not eligible for Healthy Families or full-scope Medi-Cal): up to 250% FPL * Coverage provided to income-eligible children due to immigration status. Does require premium payment for those children in families with income over 200% FPL.	Preventive and primary care services; medical office visits; dental and vision care; prescription drugs, mental health services, and needed lab tests. No coverage for hospitalizations.	Family between 200 to 250% FPL pay premium of $20 per month; under 200% FPL no premium. Co-payments range from $5-15. $25 application fee.
Kaiser Permanente Cares for Kids Child Health Program	Age 0-19: 250-300% FPL * Child enrolled in participating schools. ** Not eligible for other insurance and uninsured for at least 90 days.	Preventive, primary and specialty care, vision, prescription drugs, mental health and substance abuse services, hospital services and lab tests.	Monthly premiums are $25-35 per child, depending on family income. Co-payments of $5-10 for some services.

Attachment B: Income Eligibility Comparison Charts – Effective April 1, 2000

Medi-Cal for Children
(Gross Monthly Countable Income[15])

Number of Persons in Family	Pregnant Women and Children to Age 1	Children Age 1 to 5	Children Age 6 to 18
1	$ 0 - $1,392	$ 0 - $926	$ 0 - $696
2*	$ 0 - $1,875	$ 0 - $1,247	$ 0 - $938
3	$ 0 - $2,359	$ 0 - $1,569	$ 0 - $1,180
4	$ 0 - $2,842	$ 0 - $1,890	$ 0 - $1,421
5	$ 0 - $3,325	$ 0 – $2,212	$ 0 - $1,663
6	$ 0 - $3,809	$ 0 - $2,533	$ 0 - $1,905

*A pregnant woman is considered a family of two for purposes of this chart.

Healthy Families
(Gross Monthly Countable Income)

Number of Persons in Family	Children Birth to Age 1	Children Age 1 to 5	Children Age 6 to 18
1	$1,393 - $1,740	$927 - $1,740	$697 - $1,740
2*	$1,876 - $2,344	$1,248 - $2,344	$939 - $2,344
3	$2,360 - $2,948	$1,570 - $2,948	$1,181 - $2,948
4	$2,843 - $3,553	$1,891 - $3,553	$1,422 - $3,553
5	$3,326 - $4,157	$2,213 - 4,157	$1,664 - $4,157
6	$3,810 - $4,761	$2,534 - $4,761	$1,906 - $4,761

*A pregnant woman is considered a family of two for purposes of this chart.

[15] Gross monthly countable income definitions differ by program, but typically include earnings from a job, self-employment net profits, government cash benefits, child support, alimony/spousal support received, pensions or retirement, or other income.

Attachment B: Income Eligibility Comparison Charts – Effective April 1, 2000 (continued)

Access for Infants and Mothers (AIM)

Number of Persons in Family	Gross Family Income (annual income)	Your Total Cost for Pregnancy and Baby's First Year
2*	$22,500 - $33,750	$450 - $675
3	$28,300 - $42,450	$566 - $849
4	$34,100 - $51,150	$682 - $1,023
5	$39,900 - $59,850	$798 - $1,197
6	$45,700 - $68,550	$914 - $1,371
7	$51,500 - $77,250	$1,030 - $1,545
8	$57,300 - $85,950	$1,146 - $1,719

*A pregnant woman is considered a family of two for purposes of this chart.

Kaiser Permanente Cares for Kids Child Health Plan

Number of Persons in Family	Gross Monthly Countable Income
1	$1,741- $2,088
2	$2,345 - $2,813
3	$2,949 - $3,538
4	$3,554 - $4,263
5	$4,158 - $4,988
6	$4,762 - $5,713

Attachment B: Income Eligibility Comparison Charts – Effective April 1, 2000 (continued)

CaliforniaKids

Number of Persons in Family	Gross Monthly Countable Income
1	$ 0 - $1,740
2	$ 0 - $2,344
3	$ 0 - $2,948
4	$ 0 - $3,553
5	$ 0 - $4,157
6	$ 0 - $4,761

Attachment C: Federal Income Guidelines for Food Stamps, Head Start, The School Lunch Program, and WIC

Program	Federal Income Guidelines
Food Stamps	Gross income up to 130% of the Federal Poverty Level (FPL)
Head Start	Up to 100% FPL Allows up to 10% of enrollees to be over the income limit
National School Lunch Program	Up to 130% FPL for free lunch; 130-185% FPL for reduced price lunch
Supplemental Nutrition Program for Women, Infants and Children (WIC)	Up to 185% FPL