Reaching 100% of California's Children with Affordable Health Insurance: A Strategic Audit Of Activities And Opportunities

A Publication of The Children's Partnership
in cooperation with Children Now and the Children's Defense Fund as part of the 100% Campaign: Health Insurance for Every California Child

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EXECUTIVE SUMMARY

Of California's over 9 million children, nearly one in five has no health coverage. Today, Californians have a real opportunity to reach 100% of these kids with health coverage -- thanks to the bipartisan support that developed last summer around the implementation of the new Healthy Families program, the availability of millions of dollars of unused federal funds and money from the state's tobacco lawsuit settlement, the healthy condition of California's economy, and the number of model innovative programs currently underway in California. The first step: enroll the over 1 million currently eligible children into the new Healthy Families program and Medi-Cal. The second: find and implement solutions for covering the remaining 670,000 uninsured youngsters.

There is no single "magic bullet" to the challenge ahead. Instead, it will require the most sustained and vigorous outreach ever undertaken in California to bring kids into health care, along with targeted improvements in existing programs. In addition, it will require employers, government, health plans, counties and clinics to work together in unprecedented ways to build upon public and private sector efforts now underway so that kids not eligible for existing programs can have access to health insurance their families can afford.

This Strategic Audit lays out a roadmap for getting this job done. The analysis was carried out by The Children's Partnership in collaboration with Children Now and the Children's Defense Fund as part of the 100% Campaign. The 100% Campaign: Health Insurance for Every California Child is a coordinated endeavor of these three groups to ensure that all of California's children have quality health coverage. The Strategic Audit's contents and findings build on the extensive expertise of the 100% Campaign Partners as well as a distinguished group of experts who served as Project Advisors. The research process consisted of analyzing existing data, identifying a range of people and programs, reviewing useful material already written on the subject, and conducting extensive interviews with key sources including leaders in the health arena, employer community, public interest community, and children's field.

THE CHALLENGE

According to the UCLA Center for Health Policy Research, there are about 1.74 million uninsured children in California. These children are more likely than insured children to go without needed health care services, even when they have serious health conditions.

Over 1 million uninsured children in California are eligible for Medi-Cal (668,000) or Healthy Families (400,000).

Approximately 670,000 -- or close to 40 percent -- are not eligible for either Medi-Cal or Healthy Families. Around 410,000 of these children are not eligible because their family incomes are over 200 percent of the federal poverty level (FPL), about $32,900 a year for a family of four. The UCLA Center for Health Policy Research estimates that the remainder are undocumented children who are not eligible for these public programs.

The employment and income of a child's parents play a major role in determining whether a child has health insurance.

Workers in large firms are more likely to be covered by health insurance than those in small firms. Most firms in California with 50 or more workers (95 percent) offer dependent health insurance coverage, but less than one-third of firms with 3 to 9 employees (30 percent) do so.

Employers expect employees to carry more of the premium cost burden of family coverage. In firms with 100 or more employees, average monthly premium contributions for family coverage increased 79 percent between 1988 and 1993.

The average amount an American family pays today for family coverage through an employer totals $1,778 per year or $148 per month.

WHAT'S GOING ON FOR CALIFORNIA'S CHILDREN: BUILDING BLOCKS FOR THE FUTURE

Children in California receive health care coverage through a number of public, private and community strategies, all of which should serve as the building blocks for expanding coverage to 100% of California's children. These building blocks include:

Employment-based strategies. The majority of children in California (55 percent, or around 5 million) receive their health care coverage through the employment of a family member. Currently, there are a number of different groups in California attempting to develop new ways for employers and employees to access low-cost health insurance.

Purchasing strategies. The largest employer purchasing cooperatives in California are the Health Insurance Plan of California (HIPC) for small employers, the Pacific Business Group on Health (PBGH) for large employers, and the California Employees Retirement System (CalPERS) for public employees. Combined, these purchasing pools cover about 8 percent of the state's insured workforce. In addition, professional, trade and business associations may form pools to purchase group health insurance for their members' employees and dependents.

Public sector strategies. The cornerstones of California's public health care system for low-income children are the Medi-Cal and Healthy Families programs. With these two programs in place, children aged 18 and younger with family incomes at or below 200 percent of the FPL have access to quality health insurance. California has coupled these two programs with a number of initiatives that meet specific children's health needs.

Innovative local strategies. Across California, uninsured children receive health care services every day in their local neighborhoods through the help of the county health systems, community-based organizations and clinics, and through philanthropic support.

Individual coverage strategies. Although only around 4 percent (360,000) of all children in California receive health coverage through the individual health market, it can offer an important avenue for allowing families to provide coverage to their children. Not only do health plans offer relatively inexpensive child-only products through the individual market, there are a number of strategies underway in California by health plans to offer subsidized child-only coverage.

THE 100% PLAN FOR COVERING CALIFORNIA'S UNINSURED CHILDREN: NEXT STEPS AND RECOMMENDATIONS

Following is our recommended plan for providing coverage to California's estimated 1.74 million uninsured children. Over the next three years, the 100% Campaign is committed to moving forward on these recommendations and to working with other interested parties.

While detailed analysis of the cost of these recommendations needs to be carried out, simple calculations reveal that there is ample money available today to get the job done well. If all of the estimated 670,000 remaining uninsured children were covered through Healthy Families (which we are not recommending, but is the easiest way to look at costs), the federal and state tab comes to roughly $600 million per year. This amount is in addition to the $485 million per year in federal and state funding officials estimate it will take to cover the 400,000 uninsured children currently eligible for Healthy Families. Clearly, with California leaving approximately $2 billion in federal SCHIP funding on the table through federal fiscal year 2000 and with $23 billion in funding over 25 years expected from the tobacco lawsuit settlement, there is more than enough money available to meet this challenge.

1. *Make Medi-Cal and Healthy Families work effectively for the over 1 million uninsured kids who are eligible but not currently enrolled.*

   Californians should not underestimate how difficult it will be to make the current system work for the more than 1 million uninsured children who are currently eligible for insurance but unenrolled. Two formidable challenges are top priority: sustained and vigorous outreach in local communities across California to underscore the value of health insurance and recruit families into the programs; and a strong, clear statement from the Immigration and Naturalization Service (INS) allaying immigrant families' fears that using these programs will affect the parents' immigration status. Beyond these very high pay-off measures, a series of additional steps are needed to simplify the enrollment process and create a coordinated, seamless children's health care system.

   Shorten and simplify the Healthy Families/Medi-Cal joint application so it is easier for families and community-based organizations to use.

   Allow group eligibility determination by giving automatic eligibility for Medi-Cal and Healthy Families to groups of children already participating in means-tested programs.

   Allow the same income deductions for Healthy Families that Medi-Cal uses, thus enabling a family to use its net income, with deductions for child care, child support or alimony received, in determining program eligibility.

   Provide one year of continuous coverage and presumptive eligibility for the Medi-Cal program to make it easier to reach the nearly 670,000 children who are eligible for Medi-Cal but unenrolled in the program.

   Ensure that the cost-sharing measures of the Healthy Families program are affordable to families by gathering feedback from families on the impact cost-

sharing has on parents enrolling their children in Healthy Families, and implementing policies in response.

Increase outreach for Transitional Medi-Cal to enable parents and children moving off cash assistance to maintain their Medi-Cal coverage for up to two years.

Expand Healthy Families coverage to recent legal immigrant children who entered the country after August 22, 1996.

Allow emancipated youth to apply to the Healthy Families Program by implementing simple clean-up language.

Implement the Healthy Families employer buy-in so it fully meets the needs of families: require an employer premium contribution of 50 percent and set up simple administrative measures for identifying eligible benefit plans, tracking family co-payment expenses and structuring the payment process.

2. *Extend Healthy Families to the roughly 200,000 children in working families who cannot afford the full cost of insurance (those with annual incomes of less than $49,350 for a family of four).*

   The Healthy Families program is a sound base to build upon to expand coverage to other uninsured children. There are three principal reasons: first, it will be simplest for families (whose income circumstances change frequently) to use one program rather than a patchwork of different programs; second, because the program offers families a choice among private health plans, it avoids the stigma of welfare and is likely to be attractive to working families; and third, significant federal dollars are available at a two-to-one federal-state match to cover these children via the Healthy Families program.

   Extend Healthy Families to children with family incomes above 200 up to 300 percent of the FPL to meet a large part of the unmet need of children within this income bracket.

   Implement careful policies to ensure that Healthy Families dollars are actually used to cover currently uninsured kids and do not simply substitute for employer-provided coverage, including expanding the employer buy-in for this income group of children in order to help support employer-based coverage and fully exploring ways in which employers can be successfully motivated to provide a financial contribution to Healthy Families for covering dependent children.

   Examine options for expanding Healthy Families coverage to parents, including the possibility of implementing an employer buy-in for parents.

3. *Enable families with higher incomes to buy affordable health coverage either through the Healthy Families purchasing pool or through other community- based and private sector solutions.*

   The challenge in addressing the situation for families with incomes above roughly $50,000 annually for a family of four (300 percent of the FPL) is how to offer

them the chance to buy into affordable coverage while not undercutting the employer market which many people in this income group are already part of and which contributes 30 percent of the health care spending in California. We are suggesting several strategies that target currently uninsured children and enable parents to buy affordable coverage for their children.

Allow families above 300 percent of the FPL to buy into Healthy Families, targeting specific population groups: parents between jobs who qualify for COBRA but may have trouble paying the required amount, and self-employed or part-time workers who cannot afford coverage in the individual market.

Build on private sector strategies: encourage health plans, health systems and physician groups to provide and/or market low-cost products and subsidized coverage; work with businesses, associations and other organizations to promote increased and affordable dependent coverage and to provide resources for subsidized coverage; and support the development and expansion of purchasing cooperatives, community-based efforts and philanthropic solutions.

4. *Shore up the safety net for children who do not fit the traditional insurance model including homeless, migrant, and undocumented kids.*

California, with a disproportionately large number of children who are homeless, in the migrant stream, or undocumented, has always had special arrangements for children who do not fit the traditional health insurance model. The safety net, which consists of community and county clinics and hospitals, needs to be preserved and strengthened, especially now that many of the insured patients whose financing helped defray the costs for uninsured kids are moving into managed care plans. The number of uninsured children who will continue to turn to the safety net is substantial even with existing programs. Without making extra efforts to reach out to these children, California will continue to face high incidence of costly but preventable emergency room visits as well as serious risks to public health.

Shore up the programs that currently provide services to these hard-to-reach children, including the Child Health and Disability Prevention Program (CHDP) and Early Access to Primary Care (EAPC).

Create a Safety Net Fund with the tobacco settlement funds being allocated to counties and cities to provide health care coverage to large numbers of safety net kids and their parents.

Redirect community-based and private sector resources that have been providing care to uninsured children now covered under Healthy Families to safety net kids.
Refer families to safety net providers through targeted outreach in immigrant and migrant communities and let them know that use of these health services will not affect their immigration status.

5. *Conduct a vigorous public education campaign for parents to underscore the value of getting insurance for their children and assist them in doing so.*

   California's experience with Medi-Cal and Healthy Families makes clear that offering health insurance to 100% of children will not assure that all these children actually get coverage. So, while our recommendations will make affordable insurance available to all children, additional steps must be taken to educate parents about the value of enrolling in a plan and using services.

   A sustained public education effort with the same kind of reach and "buy-in" as "don't drink and drive" is needed to motivate families to avail themselves of the health plans available. The campaign should also help families learn how to obtain coverage. The whole range of stakeholders from employers to schools to government to the entertainment sector have important roles to play in carrying out this public education campaign. It is vital that it be a multilingual effort and that it particularly target the hard to reach families including, for example, immigrant communities, teen parents, and the unemployed.

CLOSING THE RESEARCH GAP

In researching and writing this Audit, it became clear that certain missing information must be gathered in order to develop sound plans for insuring the remainder of children in California. The key research questions that ought to be answered to ensure that California's resources are most effectively allocated include:

- What is affordable coverage for families?
- What motivates a family to obtain health coverage for their children?
- Is there a health care market for low-cost child or family products?

CONCLUSION

The goal of providing 100% of California's kids with health coverage is achievable. What is required now is for the various stakeholders to work together in unprecedented ways toward this common goal -- government, elected officials, employers, schools, the entertainment community, parents, faith communities and many others. Top priorities are to "fix" the problems with existing health coverage programs for kids and then to build up the income scale, offering affordable coverage through Healthy Families and the private sector. The last critical piece is to mount the aggressive outreach and public education campaign necessary to motivate parents to enroll their kids in health care intuitively, as they do for school. With hard work, we believe this simple but ambitious goal can be attained in three years.

INTRODUCTION AND OVERVIEW

Building upon a long tradition of leadership, California has the unique opportunity over the next couple of years to extend affordable health insurance to every uninsured child in the state. Exactly 200 hundred years ago, the earliest coverage for health services began when Congress created the U.S. Marine Hospital for Seamen, financed through deductions from seamen's salaries. Over the next two centuries, federal and state governments and employers, with the mining, railroad, and lumber industries in the vanguard, stepped up to provide health coverage to children and families. While the job of providing health insurance to families is not yet finished, several recent developments make it possible, today, to complete the job of providing 100% health coverage for children.

California, with more children than any other state, is positioned to lead the nation in reaching the basic goal of providing health insurance to 100% of its children. Today, however, California lags behind other states, with at least 18 percent of its over 9 million children without insurance compared to almost 15 percent nationally.1 The estimated 1.74 million uninsured children in California include young people who suffer from common childhood conditions like ear infections, strep throat and asthma. When not properly treated, it is not uncommon for asthma, for example, to keep a child out of school. In many cases, a parent may have to miss work on these sick days as well. For other uninsured children, an untreated ear infection may lead to hearing loss and the inability to hear well or learn in school. For others, parents' fear of an injury requiring expensive medical treatment may keep the child from competing on a school sports team or going to summer camp.

Thanks to several important developments, close to two-thirds of California's currently uninsured children now qualify for state-based health insurance programs, and the job of covering the remainder is finally within reach. Last summer, Governor Wilson and the Legislature worked together to enact a program that provides health insurance for children whose parents work at low-wage jobs, with two-third of the funds being provided from a new federal program. The new Healthy Families program, along with reforms in the state's Medi-Cal program for low-income families, make it possible for uninsured children with family incomes less than roughly $33,000 annually (for a family of four) to obtain health insurance.

It is now within our reach to enroll the over 1 million children who qualify for existing insurance programs and to find solutions for the remaining 670,000 California youngsters who continue to lack affordable health insurance. Building upon the bipartisan support for the Healthy Families program and Medi-Cal reforms, the availability of millions of dollars of unused federal funds for children's coverage specifically earmarked for California, and the healthy condition of California's economy and state budget, the job ahead can be clearly carried out. This report lays out a roadmap for getting the job done. While we recognize that insuring all children is only an incremental step toward affordable insurance for all Californians, we have structured our recommendations as sound steps that can serve as building blocks for adding other family members.

The challenge ahead, unlike other difficult social problems, is not primarily a matter of money. Nor is the answer a single "magic bullet" that lends itself to one simple action by the Legislature or by employers. Instead, reaching this 100% target will require the most

sustained and vigorous outreach ever undertaken in California to bring kids into health care, along with targeted improvements in existing programs. In addition, it will require employers, government, health plans, counties and clinics to work together in unprecedented ways to build upon public and private sector efforts now underway so that kids currently ineligible for existing programs can have access to health insurance their families can afford.

PURPOSES
This report has three purposes:

1. ***Define the job still to be done***. Provide a picture of the children who are currently uninsured and describe what is known about why they are uninsured;

2. ***Analyze the building blocks for insuring the remaining children***. Summarize what is going on in California and across the country -- in both the public and private sectors -- that can be built upon to reach the remaining kids with coverage; and

3. ***Provide a practical plan for achieving 100% coverage of children.*** Present steps that should be taken to reach out to families and provide them with affordable coverage for their kids.

ABOUT THE 100% CAMPAIGN
This analysis has been carried out by The Children's Partnership in collaboration with the 100% Campaign. The 100% Campaign: Health Insurance for Every California Child is a coordinated endeavor by Children Now, Children's Defense Fund, and The Children's Partnership to ensure that all of California's children have quality health coverage. The Campaign utilizes a combination of strategies including key partnerships with the broadest possible range of community groups and leaders, public education, new research, outreach and policy analysis to ensure that all of California's uninsured children receive health coverage. The Strategic Audit will serve as the grounding for the 100% Campaign's policy work over the next three years to expand coverage to children not currently eligible for California's new children's health programs.

THE METHOD
This investigation uses an analytic tool developed by The Children's Partnership called a "Strategic Audit." Through the Audit process, we gather, analyze and present information on a timely subject in a way that leads directly to decisionmaking. The analysis takes the form of a written product designed to be concise, accessible and geared toward action. It is written for a broad audience concerned with the well-being of children, including health professionals, policymakers, civic and business leaders, the media and grantmakers.

The research for this Audit was carried out between March and September 1998 and builds on the extensive expertise of the 100% Campaign Partners as well as a distinguished group of experts who served as Project Advisors. The process included analyzing existing data, identifying a range of people and programs to include in our research, reviewing useful material already written on the subject, and conducting extensive interviews with key sources including leaders in the health arena, employer

community, public interest community, and children's field. In addition, information provided on the programs detailed in this report was obtained through interviews conducted by The Children's Partnership. (See Appendix C for a list of people interviewed.)

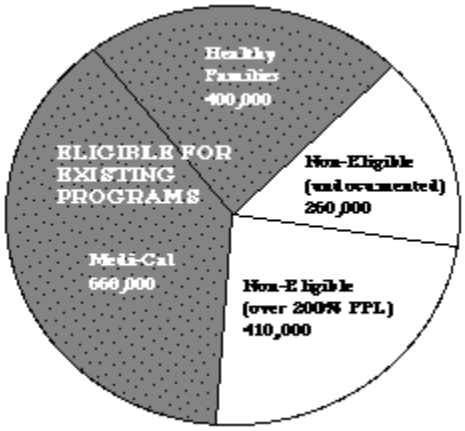
The UCLA Center for Health Policy Research provided the original data on the characteristics of California's uninsured children for this report, using information from the March 1997 Current Population Survey which asked respondents about coverage during 1996. The methodology used by the Center to analyze the CPS data is presented in Appendix D.

This Audit presents a snapshot of activities and opportunities as they stand in the fall of 1998. We realize that over the months ahead, new developments may unfold that suggest new openings or strategies. We will continue to track and analyze this changing landscape and bring forward new strategies as they are developed. Finally, we hope that the methods and structure used for this Strategic Audit can serve as a helpful resource and prototype for leaders in other states concerned with extending health insurance coverage to uninsured children.

CHAPTER 1:
UNINSURED CHILDREN: PUTTING THE CHALLENGE IN CONTEXT

California faces unique challenges to ensuring that all of its children have health coverage. This is especially evident when we look at the make-up of California's uninsured children.2

CALIFORNIA'S 1.738 MILLION UNINSURED CHILDREN, AGES 0-18, 1996
Source: UCLA Center for Health Policy Research,
Analysis of the March 1997 Current Population Survey, 1998.



The UCLA Center for Health Policy Research estimates that there are about 1.74 million uninsured children in California. The good news is that over 1 million of these children are eligible for California's new Healthy Families program or Medi-Cal. However, approximately 670,000 children -- or close to 40 percent -- are not eligible for either program, and thus will continue to go without health insurance.

It is estimated that 410,000 of these children are not eligible for Medi-Cal or Healthy Families because their family incomes are over 200 percent of the FPL, about $32,900 a year for a family of four (see Appendix E for a chart outlining federal poverty levels). The UCLA Center for Health Policy Research estimates that the remaining uninsured children are undocumented children who are not eligible for these public programs.

California's Uninsured Children Above Medi-Cal/Healthy Families Eligibility Levels: At A Glance3

Approximately 4 in 5 come from a two-parent family.

- Around 3 in 4 have a parent who is employed full-time for the entire year.
- They are pretty evenly spread among the age groups.4
- Approximately 7 in 10 live in Southern California. 5
- About a third reside in Los Angeles County.
- About 1 in 2 are Anglo.6

- More than half have family incomes of 300 percent of the FPL and below; the remaining have family incomes above 300 percent of the FPL ($49,350 for a family of four).

WHY DO CHILDREN NEED HEALTH INSURANCE?

The Institute of Medicine recently determined that insurance coverage is the major determinant of whether children have access to health care.7 It is generally agreed that for children to develop to their full potential and stay healthy, they need immunizations, regular preventive care and professional treatment for acute illnesses and injuries. Not receiving these medical services can adversely influence a child's physical and emotional growth, development and overall health and well-being. Untreated illnesses and injuries can have long-term and even life-long consequences. Numerous studies have shown that uninsured children are less likely to have access to medical services than are insured children.8

Of uninsured children with serious health conditions, nearly two-thirds with severe sore throats fail to see a doctor, and one-half with acute earaches fail to see a doctor.9

Uninsured children are three and one half times as likely as insured children to go without needed health care, including medical or surgical care, dental care, prescription drugs, eyeglasses and mental health care.10

One in four uninsured children have no usual health care provider -- compared to one out of 25 insured children who do not.11

Uninsured children receive only 70 percent of the outpatient visits that children with insurance do and between 75 percent to 85 percent of the inpatient days.12

WHAT IS THE COST OF INSURING THE REST OF THE KIDS?

Providing coverage to children is one of the most affordable and sensible ways to ensure that children grow up healthy and strong. Not only are insurance plans for children relatively inexpensive, providing coverage to uninsured children is cost-effective. It is estimated that every dollar invested in preventive care saves $10 in emergency room use, hospitalizations and treatment of learning difficulties.13 The Institute for Child Health Policy recently noted that Florida's Healthy Kids Program, which has provided health coverage to low-income children in Florida since 1992, significantly reduced the number of Emergency Room (ER) visits made by children. Of the parents of Healthy Kids' enrollees surveyed, 1 percent or less reported that the ER was their children's regular source of care, versus 11 percent of parents with uninsured children not enrolled in Healthy Kids.14

The price of providing coverage to children varies depending on the benefits offered and the purchaser of coverage.

The Healthy Families program costs $74.75 per month per child, including administrative costs and before deducting family premiums.15

Child-only plans offered by insurers in California range from $19 to $176 per child per month depending on the region, age of child, scope of benefits and plan type.16

WHY ARE THE CHILDREN UNINSURED?
While there is limited research on the specific reasons why a child would be uninsured, general research shows that employment and income play a dominant role in determining an individual's likelihood of having health insurance.17 In addition, it is important to note that almost half of the uninsured children in California above the Medi-Cal and Healthy Families eligibility levels have family incomes that are above 300 percent of the FPL ($49,350 for a family of four).18 Since these families should be better able to purchase health care coverage for their children, it suggests that some families may not see the value, especially in comparison to other family expenses, of buying such coverage.

Nationally 65 percent of individuals and 62 percent of children are covered by employment-based health coverage.19 Approximately three in four of the uninsured children in California who are above 200 percent of the FPL have a parent who is employed full-time for the entire year.20 The assumption can be made that the primary reason why a child would be uninsured is because the parents do not have dependent health care coverage through a job -- either because they are unemployed, the employer does not offer it, or what is offered is not affordable to the family.

Workers in large firms are more likely to be covered by health insurance than those in small firms.21 In California, most firms with 50 or more workers (97 percent) offer health insurance coverage to their employees. However, with small employers this picture changes dramatically. Less than one-third of firms with 3 to 9 employees (32 percent) offer health benefits and only 69 percent of firms with 10 to 25 employees do so.22 This trend holds up in firms that offer dependent coverage in California:

California Firms Offering Dependent Coverage by Firm Size, 1997

Number of Employees	Dependent Coverage Offered
3 to 9	30%
10 to 25	65%
26 to 50	81%
51 to 199	95%
200 to 299	94%
1,000 or more	99%

Source: University of California, Berkeley and the UCLA Center for Health Policy Research, The State of Health Insurance in California, 1997, January 1998. Results from a 1997 UCLA-KPMG Employer Health Benefits Survey of 1,068 California firms.

The primary reason a child loses health coverage is directly linked to the employment of his or her parent. Up to 62 percent of America's children who lose coverage do so because of some form of break in employment-based coverage -- either their parents

change jobs or they age-out of the employer policy. While the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to make coverage available for up to 18 months to terminated employees and their dependents, the individual is required to pay the full premium. As few as 18 percent of eligible persons nationwide take advantage of COBRA.23

Even if all employers offered coverage to their employees and dependents, only part of the problem would be solved. In actuality the number of employers offering coverage to employees in the last few years has increased. However, there has been a decrease in the number of children and adults covered by employer coverage. Between 1989 and 1995, the national percentage of children with private health insurance dropped from more than 73 percent to 66 percent.24

Recent studies have shown that even though an employer may offer coverage, the employee cannot necessarily afford to take advantage of what is offered. In fact, in recent years employers have expected employees to carry more of the premium cost burden, with family coverage being particularly impacted.25 Nationally:

- The monthly contribution for family coverage for workers in firms with fewer than 200 workers increased from $34 to $175 between 1988 and 1996.26

- In firms with 100 or more employees, average monthly premium contributions for family coverage increased 79 percent between 1988 and 1993.27

- Between 1989 and 1996 cost increases for family premiums were 13 to 23 percent higher than cost increases for employee-only plans.28

In addition to the high cost of family coverage, national figures show that an employee's share of premium costs is higher for family coverage -- 30 percent for family coverage in 1996 compared to 22 percent for employee-only coverage.29 Between 1989 and 1996 the national average annual premium per family for family coverage among firms with over 25 employees was $5,318. On average the employer contributed between 64 and 70 percent of the premium. A family choosing the lowest cost plan (an HMO) would have to pay a total of $1,778 per year for family coverage versus the average of $525 for employee-only coverage.30

The families who are ineligible for Healthy Families or Medi-Cal and who are not offered dependent health coverage through their employer or cannot afford that coverage currently have limited options for seeking out coverage from other sources, mostly due to the unaffordability of such coverage. This is particularly true for the uninsured children who are undocumented, since the UCLA Center for Health Policy Research estimates that a large majority of these children come from families with incomes below 200 percent of the FPL.

WHAT IS AFFORDABLE HEALTH CARE COVERAGE?

Health insurance coverage is so heavily linked to income, that one of the most important questions to ask when designing programs for the uninsured is: what is affordable coverage? Little definitive research has been conducted on that question. What studies exist suggest is that consumers at lower incomes are quite sensitive to the out-of-pocket costs of health insurance.

- A Lewin Group study of Washington's Basic Health Plan premium rates found that when premium contributions represented 7 percent of household income, only 10.3 percent of eligible persons bought the coverage; when the premiums rose to 16 percent of household income, only 5 percent bought the insurance.31

- In early 1997 the Urban Institute conducted a study examining the relationship between the premium scales and participation rates in four state health insurance programs for low-income residents: Hawaii's QUEST, Minnesota's MinnesotaCARE, Tennessee's TennCare, and Washington's Basic Health Plan. It found that when premiums are 1 percent of income, 57 percent of the uninsured would participate, but at 3 percent of income only a third (35 percent) would do so and at 5 percent of income only a sixth (18 percent) would participate.32

- As was previously discussed, the average amount a family pays today for family coverage through an employer HMO plan totals $1,778 per year or $148 per month. For a low-income family of four at 225 percent of the FPL ($37,013) this represents almost 5 percent of their income.33

Another way to frame the affordability issue is to look at a typical budget for a family of four. As the pie chart below shows, a family consisting of 2 parents, a 3 year old child and a 7 year old child with an annual family income at 225 percent of the FPL ($37,013) has very limited resources.34 After paying for the basic necessities of Housing and Utilities35, Food36, Child Care37, Transportation38, and Taxes39, this family has $189 each month to cover everything else including phone, clothing, laundry, school supplies and personal items, not including health care coverage for them and their kids. Clearly this family would need a significant subsidy to afford insurance for their children.

A FAMILY'S MONTHLY BUDGET AT
225 PERCENT OF THE FEDERAL POVERTY LEVEL

Two parents, a 3 year old child and a 7 year old child
with an annual income of $37,013 or $3,084 per month.

[Chart]

CHAPTER TWO:
BUILDING FROM THE PRESENT: A CONTEMPORARY LOOK AT WHAT'S GOING ON FOR CALIFORNIA'S CHILDREN

Children in California receive health care coverage through a number of public, private and community strategies, all of which will serve as the building blocks for expanding coverage to 100% of California's children. The following provides an overview of these building blocks: employment-based strategies, purchasing strategies, public sector strategies, innovative local strategies and individual coverage strategies. (See Appendix F for a matrix of the California programs discussed.)

EMPLOYMENT-BASED STRATEGIES

The American health care system relies heavily on the employment sector to provide individuals with health insurance. As such, the majority of children in California, around 5 million, receive their health care coverage through the employment of a family member.

California, however, has a significantly lower rate of individuals and children covered by employment-based coverage than are nationally, with only 57.8 percent of non-elderly Californians -- compared to 65 percent nationally -- and 55 percent of California children -- compared to 62 percent nationally -- obtaining health insurance through their employment or through that of a family member.40 This low rate of employment-based coverage could be due to the number of low skill, low wage jobs and part-time or temporary jobs in California that typically do not offer health insurance, such as those in agriculture, construction, retail and food services.

In 1992 California implemented a number of reforms in the small group market to make it easier for small employers to provide health care coverage to their employees. The reforms included a guarantee of availability, renewability, portability, premium stability and limits on pre-existing condition exclusions of health coverage for small employers with between 2 and 50 full-time employees. It is estimated that four million Californians are covered through small employers affected by these provisions.41 In addition, the legislation created a statewide purchasing cooperative to negotiate price benefits with carriers for small employers. (See the Health Insurance Purchasing Cooperative following.)

Even with these market reforms, many small businesses still do not offer health insurance to their employees, most often citing the high cost of premiums. 42 In 1989 California passed legislation that would provide small employers with health coverage tax credits but the bill was never implemented for fiscal concerns. It was estimated at the time that the program would cost the state $400 million annually but that only 5 percent of the participating groups would be new insurers, the rest already providing coverage to their employees without the tax credit. California's experience with an employer tax credit exemplifies the difficulty with such an option -- it is hard to target it to businesses not offering coverage or make it substantial enough to attract them to do so. A Robert Wood Johnson report found that only between 5 and 16 percent of employers currently not providing coverage would do so if a subsidy was provided.43

There are some different groups in California attempting to develop new ways for employers and employees to access low-cost health insurance:

- *Sharp Health Plan:* Sharp will implement this fall a two-year demonstration product for uninsured small businesses (2 to 50 employees) in San Diego County. The program, entitled FOCUS, will provide subsidized health coverage to low-income, uninsured employees with incomes of 100 percent up to and including 300 percent of the FPL and their dependents. Members must be uninsured, and must not be eligible for Medi-Cal or Healthy Families. Benefits will include primary and preventive care services, inpatient hospitalization, urgent and emergency care, outpatient mental health coverage, and prescription drugs. Most routine services will require a $5 co-payment and monthly premiums will be set on a sliding scale between 1 and 4 percent of income. Employers will also be required to contribute a premium, though lower than they would pay for commercial small group coverage. A key goal for FOCUS will be to convince uninsured businesses that they can afford to sponsor health benefits, and can even profit through lower absenteeism, and increased morale and retention. The program has the capacity to serve 1,100 to 1,400 members over the two-year period. Funding for FOCUS is provided by the Alliance Healthcare Foundation, with an evaluation funded by the California HealthCare Foundation.

- *Community Health Group:* CHG, a San Diego-based health maintenance organization, has been providing health care services to residents of San Diego County since 1982. In October 1997 CHG launched a commercial product focused on low-cost health plans for businesses that do not offer insurance to employees. CHG's sales process educates first-time buyers (employers and employees) about the value of health insurance, how to purchase it and how to use it. The administrative services are provided at no cost by the plan during the start-up period and are fixed thereafter. Earlier this year, CHG was named the Community Provider Plan for the Healthy Families program in San Diego County.

- *Adecco, Inc.:* Adecco, an international temporary employment agency, offers access to a cafeteria-style purchasing pool for its employees and their spouses and dependents (domestic partners are not covered). To participate in the insurance pool, employees must work a minimum of 20 hours per week for 8 consecutive weeks. Benefits include basic medical and dental care. The cost for participation for an individual is $51.60 for medical and $17.80 for dental per month. For an individual with an unlimited number of dependents the cost is $144.60 for medical and $50.80 for dental per month. There is also a $15 co-pay for in-network doctors fees. Premiums are deducted directly from paychecks. Employees losing employment after enrollment can continue their coverage by mailing payments directly to the insurance broker.

- *Hotel and Restaurant Employees Union (HERE):* HERE provides a benefits package with very low co-pays to part-time employees belonging to the union. A significant number of HERE employees work for several different employers and/or on an "as-needed" basis. The union tracks and banks their hours to ensure continued coverage, and takes special care to spread out work assignments so that members can meet minimum hours required for coverage.

- *Motion Pictures and Television Fund (MPTF):* MPTF, an entertainment industry-based effort, provides health coverage to individuals through an MPTF preferred provider network. Those who are eligible include employees in motion pictures, television, video, cable, radio, theater/stage, dance, music, studio theme parks, entertainment industry media, academies, distribution and other related industry fields in Southern California. Spouses, children and parents are also eligible for coverage. Health benefits vary by health plans and services are provided at MPTF health centers. MPTF also initiated Health Access 2000, which is researching ways to expand health care access within the Southern California entertainment industry, focusing on potential expansion and replication of current programs.

PURCHASING STRATEGIES

Efforts to control health care costs have led in recent years to the creation of purchasing cooperatives. Purchasing cooperatives allow groups of employers to join together to jointly negotiate and purchase health care coverage from health plans or insurers. Premium savings are achieved by using the combined purchasing power of the group to bargain with carriers for reduced premiums and by the reduced administrative costs achieved for such expenses as marketing, enrollment and premium collection. The cooperatives typically standardize benefits and use their purchasing power to influence health plans to improve performance on outcome measures.

The largest employer purchasing cooperatives in California are the Health Insurance Plan of California (HIPC) for small employers (discussed later), the Pacific Business Group on Health (PBGH) for large employers, and the California Employees Retirement System (CalPERS) for public employees. Combined, these pools cover about 8 percent of the state's insured workforce.44 In addition, professional, trade and business associations may form pools to purchase group health insurance for their members' employees and dependents. One example includes:

- *Western Growers Association:* For more than 40 years, WGA has provided limited low-cost health insurance to full-time, part-time and seasonal workers in the agricultural business. The association concentrates on expanding coverage in rural areas, where workers are more likely to be uninsured, and has arrangements with health plans as well as direct contracts with providers. Employers provide basic health coverage with low premiums and low co-payments for employees and their families. In some areas WGA contracts with community clinics to pay claims when employees are not working. These clinics also assist employees in obtaining Medi-Cal coverage during periods of unemployment which allows for continuous care from the same provider and assures clinic payment. According to WGA, the program covers 30,000 employees and their dependents for a total of 90,000 lives, or approximately 75 percent of WGA members.

In addition, three private entities in California have attempted to establish purchasing cooperatives, but with less success. Two were started by agents and brokers, California Choice and Benefits Alliance, and operate as marketing alliances, meaning that they offer several benefit designs and rates they have developed and negotiated with health plans, but participating firms contract directly with the health plan. California Choice reports it has 42,000 employees and dependents in the small group market.45 The third,

CalSERS, was created by The California Small Business Association to provide integrated health and workers' compensation to small and mid-size businesses, but it is no longer in existence. In 1996 California passed legislation (SB 1559) creating a regulatory mechanism for purchasing cooperatives with oversight by the Department of Insurance. To date, no entity has been certified nor are any currently seeking to be.46

There is little evidence to show whether purchasing cooperatives have an impact on covering uninsured children. As their reach is limited to specific groups of individuals, they tend to act like other employer groups in the ways they offer dependent coverage, and the pricing of family coverage is still unaffordable for low-income families without some type of subsidy.

The Health Insurance Plan of California (HIPC): The same legislation that implemented small group market insurance reforms in 1992 also created a statewide purchasing cooperative that could negotiate price and benefits with carriers for small employers. The HIPC was launched in 1992 under the administration of the Managed Risk Medical Insurance Board (MRMIB) to serve as an intermediary between small employers (those with 2 to 50 employees) and health plans by negotiating contracts with plans, collecting premiums from firms and distributing them to the plans. As of April 1998, 7,400 firms and 137,000 enrollees were participating in the HIPC.47 Under the program, employees choose from any health plan that the HIPC offers in their geographic region. The benefits are standardized among the plans but there are two levels of co-payments for consumers to choose from. Employers are required to contribute 50 percent of the premium for the lowest-cost, employee-only plan and 70 percent of eligible employees must participate.

The HIPC's success in making health coverage available and affordable to small employers has been mixed. Its share of the small group market is currently about 3.5 percent.48 In a recent survey only 30 to 32 percent of small employers were aware of its existence and the broker community has never completely bought into it.49 In addition, the HIPC has had the same impact that the small group market has had on covering the uninsured. According to MRMIB, 19.3 percent of the groups in the HIPC as of July 1997 were previously uninsured -- which is similar to the rest of the small group market.50 However, according to experts, the HIPC has established itself as a national model by successfully transforming market premiums set by carriers into negotiated premium rates to which the market has had to respond.

The legislation creating the HIPC also included language for MRMIB to initiate a process for turning the purchasing cooperative over to a nonprofit entity. After a few unsuccessful attempts to do so, the HIPC is slated to be taken over by the Pacific Business Group on Health in July 1999. If this privatization of the HIPC is successful, MRMIB will repeal the current regulations governing the HIPC, providing PBGH with wide latitude in determining such things as the number of plans offered, co-payment and premium levels, the benefit package design and its marketing strategy. There are expectations that this will allow the HIPC to expand its reach within the small group market.

PUBLIC SECTOR STRATEGIES

The cornerstones of California's public health care system for low-income children are the Medi-Cal and Healthy Families programs. With these two programs in place, children 18 and younger with family incomes at or below 200 percent of the FPL have access to

quality health insurance. California has coupled these two programs with a number of related programs that meet specific children's health needs.

Medi-Cal: The Medi-Cal program is the primary funder of health care for low-income children in California. A total of 22 percent (over 2 million) of all children in California receive their health care coverage through Medi-Cal. In addition, it is estimated that of the almost 1.74 million uninsured children in California, 668,000 -- or 38 percent of all uninsured children -- are eligible for but not enrolled in the Medi-Cal program.51

Medi-Cal provides a comprehensive range of health benefits for children, including inpatient and outpatient hospital services, physician and laboratory services, preventive care, vision and dental care and mental health services. Eligibility for the Medi-Cal program is determined in most cases by whether the family's income falls below a certain level. California recently used funding from the 1997 federal State Children's Health Insurance Program (SCHIP) to expand its income-eligible Medi-Cal program to cover more teenage children, to drop the assets test for children and to create a simpler application. Beginning April 1998 the income eligibility rules for income eligible Medi-Cal were:

Age of Child	Family Income 52
under 1	200 percent of the FPL = $32,900 for a family of 4
1 - 5	133 percent of the FPL = $21,879 for a family of 4
6 - 18	100 percent of the FPL = $16,450 for a family of 4

Other categories of Medi-Cal eligible children are those already receiving Social Security Income (SSI) benefits (for children with disabilities), and children in families with assets below a certain amount can receive Medi-Cal benefits by paying a share of the cost. Prior to the federal welfare reform law, children who received Aid to Families with Dependent Children (AFDC) benefits (cash assistance) also automatically qualified for Medi-Cal. As a result of the new federal law and the replacement of AFDC with the Temporary Assistance for Needy Families (TANF) program, this is no longer the case. Instead, children who would have qualified for AFDC under the rules in effect on July 16, 1996 are still eligible for Medi-Cal but they must enroll in the program separate from TANF.

A child is eligible to receive Medi-Cal for up to two years if his or her parent loses eligibility for TANF benefits due to increased income. The Transitional Medi-Cal (TMC) program is an important safety net for families as they move off cash assistance to mostly low-wage jobs that do not provide health insurance. However, the California Legislative Analyst's Office estimates that between 110,000 and 150,000 individuals leave cash assistance every month but that less than 10 percent participate in TMC. In December 1997, approximately 84,000 individuals were participating in the program.53

Healthy Families: The main vehicle California chose for spending its SCHIP funds is a new separate children's health program called Healthy Families. Administered by the MRMIB, Healthy Families is a partially subsidized insurance program that provides health, dental and vision coverage to children. It is estimated that 400,000 uninsured

children in California are eligible for Healthy Families. This means that of the almost 1.74 million uninsured children in California, 23 percent are eligible for health coverage through this program.54

Healthy Families is available to children who are ages 1 through 18 and in families with incomes that are too high for Medi-Cal, but below 200 percent of the FPL ($32,900 for a family of four). Children with previous employer-based insurance must have been uninsured for the prior three months unless certain exceptions apply. In addition, as with the Medi-Cal program, the children must be U.S. citizens or legal immigrants who arrived in the U.S. before August 22, 1996 unless certain exceptions apply. Families apply for the program by using a joint mail-in Medi-Cal/Healthy Families application. Under this program, families are responsible for sharing the cost of coverage and care by paying:

- $7 per child monthly premiums for families with incomes of 101 percent to 150 percent of the FPL ($16,450-$24,675 a year for a family of four). These families pay no more than $14 per month for all their children.

- $9 per child monthly premiums for families with incomes of 151 percent through 200 percent of the FPL ($24,675 to $32,900 a year for a family of four). Such families pay no more than $27 per month for all their children.

- If families choose a Community Provider Plan -- the health plan in their region with the most safety net providers -- they receive a $3 per child monthly discount.

- Families must pay $5 co-payments whenever they seek health care (except for preventive services such as check-ups and immunizations), up to an annual family maximum of $250.

Under the Healthy Families legislation, the Department of Health Services and MRMIB were also authorized to operate Rural Demonstration Projects (RDPs) to fund rural health care projects that provide increased access to health care in rural areas that have a significant number of uninsured children. A total of $5 million in general fund dollars was appropriated for four projects (two administered through DHS and two administered through MRMIB). In addition, the state is attempting to acquire a federal match of $4 million through SCHIP for two of the projects. The specifications include providing:

1. Rate enhancements to current Healthy Families health, dental and vision plans that expand services without regard to geographic boundaries;

2. Rate enhancements or grants to Healthy Families health, dental and vision plans that develop services in isolated underserved rural areas;

3. Grants to health care providers that deliver health care services to special populations; and

4. Grants to health care organizations/providers to develop or enhance their capabilities to make services available to eligible children in targeted geographic rural areas.

Employer Buy-In: Another piece of the Healthy Families legislation included an employer buy-in or purchasing credit. Under the program, California would use its SCHIP funding to subsidize coverage for an uninsured child whose parent works for an employer who offers dependent coverage. Although the employer buy-in was not implemented in 1998 due to technical changes that needed to be made to the legislation, state officials expect to implement the program during the 1998-99 legislative year.

An employer buy-in has certain attractive features. First, it allows a child to enroll in the same health plan as his or her parent. Second, it requires an employer to contribute to the cost of providing coverage to its employees' child, in effect leveraging more out of the SCHIP dollar. Although California has not stipulated a minimum employer contribution, federal officials have stated their desire that an employer contribute at least 60 percent of the premium. State officials are hopeful that federal officials will be flexible on this point because Massachusetts recently received approval for an employer buy-in requiring employers to contribute at least 50 percent to the cost of coverage.

One concern about the employer buy-in is that it could lead to employer crowd-out (employers reduce their premium contributions and have the state pick up the cost). However, it has also been argued that an employer buy-in helps to shore up employer-based coverage by giving employers the benefit of providing coverage to their employees at a lower cost, while at the same time ensuring that they remain primarily responsible for their employees' coverage. Additional concerns are related to the administration of such a program and the comparability of benefits. Under federal law, the benefit package offered by the employer would have to meet the same guidelines that any SCHIP benefit plan does. The California legislation stipulated that the employer-based coverage be 95 percent actuarially equivalent to the Healthy Families benefits and, if not, that supplemental coverage, such as vision and dental, be provided through Healthy Families. Knowing that the range of plans offered by employers varies considerably, determining what plans are equivalent to the Healthy Families plan and then providing various supplemental coverage to make them equivalent could be administratively difficult for both the state and families. It is also important that any plan approved as a SCHIP benefit plan meets the federal requirements and Healthy Families standard, in terms of what the family has to pay for deductibles, premiums and co-payments.

Last, it is important to create an administrative structure that is workable for families and employers. Whether the subsidy is provided to the family, to the employer or to the health plan will have important implications for whether the administrative burden is placed on the family or employer, for employee privacy, for fiscal oversight by the state and for crowd-out.

Although the employer buy-in concept is an interesting model, its track record is limited since only a few states have implemented such programs:

- Oregon's Family Health Insurance Assistance Program is currently funded by a state tobacco tax, though plans are being made to integrate the program with the state's SCHIP plan down the road. It has been operational since July 1, 1998. As designed, the program will make payments directly to employees upon showing that they are enrolled in the employer plan and in advance of their payroll deduction. This structure is intended: 1) to make the program as simple as possible; 2) to make it financially possible for employees to participate; 3) to

maintain confidentiality; and 4) to minimize crowd-out, since some believe that an employer who plays an administrative role -- and is thus fully aware of the subsidy available -- would be more likely to drop coverage and have their employees take advantage of the public program.

- Massachusetts has received HCFA approval for its MassHealth Family Assistance Plan, originally approved under an 1115 waiver and since redesigned with the passage of SCHIP. It is scheduled to become operational by the end of August 1998. It is structured to include both payments directly to the employee and payments to third party administrators, depending on the source of funding (i.e. SCHIP or the 1115 waiver). Massachusetts has approval to require just 50 percent minimum contribution of employers. And, it has approval to cover currently insured, income-eligible employees. These two unusual components of the program had already been approved under the 1115 waiver.

Access for Infants and Mothers (AIM): AIM is a subsidized health insurance program for pregnant women and children up to two years of age in families with incomes at 200 and up to 300 percent of the FPL. Benefits include services related to maternity, delivery, infant care and prescription drugs. Participants in the AIM program are responsible for monthly premiums equal to 2 percent of their family income in the first year, plus $50 in the child's second year (with proof of immunization). Since its inception in 1991, the AIM program has provided health care services to over 35,000 women and infants.55

AIM is administered by MRMIB which purchases insurance from several private plans. Funding for AIM comes from the Perinatal Insurance Fund, Proposition 99 tobacco tax funds and some federal funds. Enrollment in the program is limited to the funds appropriated each year which for 1997-98 totaled around $39 million.56

California Children's Services (CCS): CCS serves low-income children with serious medical problems, such as critical acute illnesses, chronic illnesses, genetic diseases, physical handicaps, major injuries due to violence and accidents, congenital defects, and conditions requiring treatment in neonatal or pediatric intensive care units. CCS utilizes the services of specialty doctors and centers that meet the program standards to provide the care. Benefits include physician care, hospitalization, laboratory services, x-ray, rehabilitation services, medications, and medical case management. To be eligible for the program, children must be under 21, have a medical condition covered by CCS, be a resident of the county, have an adjusted gross family income below $40,000 or a projected out-of-pocket medical cost greater than 20 percent of the family income. The program is funded by state general funds (50 percent) as well as county funds (50 percent).57 Medi-Cal covers the costs of children receiving CCS services who are also eligible for Medi-Cal. In 1996-97 the program received $48 million in county funds, $48 million in state funds, $571 million from Medi-Cal funds for children with CCS eligible conditions, and provided services for a total of 128,500 children.58

Children's Health and Disability Prevention Program (CHDP): Implemented in 1974, CHDP provides children with regular health assessments and immunizations. Children eligible for CHDP services include those up to age 21 who qualify for Medi-Cal, non-Medi-Cal children up to age 18 from families with incomes up to 200 percent of the FPL, and young children in Head Start and state preschool programs. Under the program, children are eligible to receive necessary follow-up treatment for medical conditions identified in the CHDP screen, either through Medi-Cal or through a separate state-

funded program. CHDP is administered by local health departments. In 1997-98 it is estimated that California spent $83.6 million on CHDP services. Funding for CHDP comes from state and federal general funds as part of Medicaid, and Proposition 99 tobacco taxes. 59

Expanded Access to Primary Care (EAPC): EAPC, administered by the Primary and Rural Health Care Systems Branch of the Department of Health Services, provides annual funding to primary care clinics (350 in FY 1997/98) that provide preventive health care to medically underserved areas and populations. The funding must be used to serve individuals who have family incomes below 200 percent of the FPL who do not have any third-party health or dental coverage. Funding for EAPC is provided through Proposition 99 tobacco tax monies. In FY 1996/97 California spent $13.8 million for 254,535 client encounters.60

INNOVATIVE LOCAL STRATEGIES

Across California, uninsured children receive health care services every day in their local neighborhoods through the help of county health systems, community-based organizations and philanthropic support. The following is a sampling of some of these activities.

Community Clinics: An extensive network of community or free clinics across California provides essential services to uninsured children and families. Many of these clinics are the only entry points for uninsured children. There are a total of 696 community clinics in California.61 Just one example of such a clinic is the Venice Family Clinic in Los Angeles which sees a total of 17,000 individuals each year, 99 percent of which are uninsured and 36 percent are children. The Venice Family Clinic receives its funding from the state, county, foundations, donations and fundraising activities.62

County Health Systems: Counties have responsibility under California state law for delivering health services to the uninsured poor. In 1995-96, counties spent at least $1.4 billion on care for the uninsured.63 Counties use a variety of funding sources to cover indigent services. The largest source of funds comes from a half cent state sales tax and a portion of vehicle license fees which the state transfers to counties. In addition, counties use county tax revenues and general funds, Proposition 99 state tobacco taxes, and some state general fund money.64 Counties also receive funding through the federal Disproportionate Share Hospital Supplemental Payment Program (DSH), which helps hospitals that treat large numbers of Medi-Cal and indigent patients. In 1994-95 DSH payments totaled $2.2 billion, $1.1 billion in county funds and $1.1 billion in matching federal funds.65

Due to budget cuts, health marketplace competition, the move towards managed care and increases in the costs of serving uninsured individuals, California's local governments have started to experiment with ways to utilize their limited funds to serve the growing uninsured populations more efficiently.

- *The Local Initiative Health Plans:* Currently eight counties in California have implemented a two-plan model in which Medi-Cal recipients have been, or are being, shifted into two managed care health systems: the Local Initiative or a commercial health plan. The Local Initiative is quasi-public entity that is locally operated and includes the county health care system and other local providers.

Since the Local Initiatives are not-for-profit some have started to examine ways to use reserve funding to help support community health services. The Health Plan of San Joaquin implemented a program, CareFree Kids, last year in which it continued to pay the premiums of children within the plan who lost Medi-Cal eligibility because of an increase in their income. The Alameda Alliance for Health, as part of its slate of programs to serve indigent populations, has issued over $1 million in grants to community providers and programs.

- *San Diego County:* Officials in San Diego County are currently exploring ways in which the county can aggregate public patient care dollars including Medi-Cal, indigent care and Healthy Families into a single local purchasing entity. Savings achieved through the purchasing pool would be used to create a subsidized premium program for uninsured individuals in San Diego. The proposal was among the recommendations made to the county by a national panel of experts it convened to examine public-private strategies to improve the health of San Diegans. The proposal is currently at the committee stage, and officials expect implementation to be on a two to three year timeline.

- *City & County of San Francisco:* In May of 1998 Mayor Willie Brown's Blue Ribbon Committee on Universal Health Care unveiled its proposal for expanding health care coverage to uninsured San Franciscans. Under the plan the city and county of San Francisco would pool the funding they spend for employee and retiree medical coverage with federal and state health care funds in order to provide coverage to an estimated 130,000 uninsured individuals in San Francisco. Small businesses that do not currently insure their workers would be eligible to join the pool and take advantage of the low-cost premiums the pool is expected to offer (estimated at $139 per month per enrolled person). Employers would be required to contribute at least 50 percent of the premium for their full-time employees, with the employee paying 25 percent of the premium and the city and county paying the rest for residents who earn less than 300 percent of the FPL. In addition, children with family incomes above 200 percent of the FPL would be eligible for the pool along with part-time workers, college students and unemployed adults. Subsidies would be provided for unemployed adults. Benefits would include inpatient and emergency hospital care, prescription drugs, home care and limited mental health and substance abuse services.

Although Mayor Brown has placed the proposal on the November 1998 ballot as a nonbinding resolution to gain public support, its implementation has been slowed by opposition from unions. The city government retirees' association opposes the measure because they fear the plan will erode their benefits. The Service Employees International Union (SEIU) is concerned about the possible loss of public funding for San Francisco General Hospital and other public health clinics, where a large number of union members work, when that money is diverted into the pool.

Voluntary Physician Models: The volunteer-based physician model has been implemented in many communities across California. Under the model, a network of physicians provides access to health care for uninsured and underserved children from low-income families.

- *Young & Healthy (Pasadena, CA):* Young & Healthy was an early implementer of the voluntary physician program. It has served as a model for a number of sites

throughout California including Glendale (Healthy Kids), Marin County and Sonoma County, as well as in Ohio and Kansas. Created in 1990 by the All Saints Church to address the needs of uninsured children in Pasadena, CA, the program provides free services through a network of 300 volunteer physicians, dentists, optometrists and other health care professionals who provide single services and in some instances `medical homes' for children with chronic conditions, such as diabetes, who would otherwise have no access to regular care. Young & Healthy receives funding from foundations, private contributions, special fundraising benefits and volunteers. According to Young & Healthy, during the 1996/97 academic year, 1,229 kids were provided with 12,000 units of service.

With approximately 15,000 children in its target population now qualifying for one of several child health initiatives (Medi-Cal, Healthy Families, CaliforniaKids, Kaiser Permanente Cares for Kids Child Health Plan, etc.), Young & Healthy is developing an outreach and referral system to get kids enrolled in the new programs.

- Kids Stay Healthy: Brown & Toland Medical Group, a San Francisco-based independent physicians' association, and the San Francisco Medical Society are working with a number of San Francisco hospitals and other San Francisco-based medical groups to develop a network of providers to offer health care for uninsured children with family incomes above 200 percent and up to 275 percent of the FPL. Under the initiative, each medical group will be responsible for providing health care to a specific number of children in San Francisco County. The Kids Stay Healthy pilot program is slated to begin in January 1999, and has the capacity to serve up to 500 children in its first year. Program benefits and the fee schedule are still under discussion. In order to reach as many uninsured children as possible, Brown & Toland is also hoping to coordinate Kids Stay Healthy with other programs, such as Healthy Families, CaliforniaKids, etc., to link low-income children to appropriate sources of care.

INDIVIDUAL COVERAGE STRATEGIES

The health insurance market for individuals is relatively small in California, as in the rest of the county, with only around 6 percent of the population buying individual health coverage.66 For children, the number is even smaller. In 1996, 4 percent of all children in California (360,000) had privately purchased individual health coverage.67

The individual market tends to have higher costs and fewer choices than the employer market (also called group market), making it an unlikely option for individuals without employer-based coverage. The small employer market reforms of 1993 were not applied to the individual market, so individual purchasers of health care have few of the protections provided to small businesses. This includes no guarantee of the issuance of policies, no limits on pre-existing condition exclusions, no rights to change coverage, and no grace period during job changes or unemployment.

The individual market can, however, offer an important avenue for providing families coverage for their children. Not only do health plans offer relatively inexpensive child-only products through the individual market, there are a number of strategies underway in California by health plans to offer subsidized child-only coverage.

Child-Only Plans: A child-only product sold by a health plan allows a family to purchase coverage for a single child -- without an adult on the policy -- in the individual insurance market. The child-only plans offered by health plans in California vary considerably by price ($19 to $176 per month per child), with the monthly premium rates based largely on age, geographic location, plan type (HMO or a traditional plan), and product design, including deductible and cost-sharing options. (See Appendix G for a list of health plans in California offering child-only products.)

Child-only health plans represent a relatively small share of the total individual sales for health plans. Typically the consumers targeted for these plans have been divorced parents who are required to provide health insurance for their children and grandparents who are retired but caring for their grandchildren.68 Interviews conducted with health plans in California and nationally revealed that the low utilization rate has a lot to do with the limited marketing done by health plans, with health plans spending the majority of their marketing dollars on areas where they perceive there to be greater market demand. 69 Blue Cross, for example, conducts little of its own marketing for the child-only plans, relying almost exclusively on insurance brokers to market them.70

National research backs up these findings. The United States General Accounting Office (GAO) recently interviewed carriers and agents across the country on the availability and marketing of child-only products. They found that the child-only products represented a small share of most carriers' total individual health insurance sales -- from under 1 percent to 20 percent.71 The companies interviewed felt that the demand for the policies was quite low and thus were not willing to aggressively market them. In addition, since children's products are often priced lower than other plans, agents interviewed did not feel the commission amount, usually based on a percentage of the premium, was a strong incentive for selling the products.

Another important reason for the low utilization rate of the child-only plans is the lack of underwriting reforms in the individual market. For this reason, a parent seeking a child-only plan in California could be denied coverage because of his or her child's pre-existing condition. The GAO report found that the carriers they interviewed decline between 5 and 15 percent of child applicants. Health plans usually require underwriting out of concern for adverse risk selection -- that is, they are concerned that the parents who would seek out a child-only plan would be those with sick children.

CaliforniaKids: The CaliforniaKids Healthcare Foundation was founded in 1992 by Blue Cross to provide access to health care for uninsured children in California. The non-profit organization subsidizes premiums for uninsured children ages 2 through 18. Health care benefits include outpatient, preventive and primary services, with no inpatient hospital or surgical care. Children in the program must not be eligible for Medi-Cal, Healthy Families or enrolled under any private health care plan. Total health care coverage costs about $400 per child per year. The subsidies are provided by foundations, businesses, community organizations and individuals. The program requires a co-payment ranging from $5 to $25 for office visits, prescription drugs, dental and vision care services.

With CaliforniaKids' targeted population now eligible for the Healthy Families program, it is anticipated that nearly 8,000 children will transition from CaliforniaKids to Healthy Families over the next few months. CaliforniaKids is in the process of implementing a program to reach families with incomes over 200 and below 300 percent of the FPL, undocumented children and youth emancipating from the foster care system. Under the

new program, families will be responsible for paying monthly premiums ranging from $20 to $35 per child, as well as co-payments for services. With this expansion, it is estimated that an additional 10,000 uninsured children will receive health insurance.

Kaiser Permanente Cares for Kids Child Health Plan: In June 1998, Kaiser Permanente began conducting outreach and enrollment activities for its Child Health Plan, through which children from families with income above 200 percent and below 275 percent of the FPL receive subsidized coverage. Kaiser Permanente is working with schools and school districts throughout the state of California to target children from birth up to age 19, who are enrolled in participating schools (or whose siblings are), whose family income exceeds eligibility for Healthy Families, and whose parents either have no access to employment-based coverage or are not eligible for employment-subsidized dependent coverage. As part of its outreach activities, Kaiser Permanent is also referring children who do not qualify for the Child Health Plan to other public and private programs for which they may be eligible. Monthly premiums for the Child Health Plan range from $25 to $35 per child, depending upon income; co-payments range from $5 to $10. The average subsidy exceeds 60 percent of the premium. Participants in the Child Health Plan receive the same benefits offered to other Kaiser Permanente members, including preventive care, physician visits, emergency services, hospital care and prescription drug coverage. Along with a HIPC dependent coverage subsidy pilot expected to be implemented in 1999, Kaiser Permanente has the capacity to serve up to 50,000 children per year over the next five years.

MediFAM: MediFAM is a health care product developed by Blue Cross of California in partnership with the Chicano/Latino Medical Association of California, Family Care Specialists and White Memorial Medical Center in East Los Angeles. Beginning in 1997, the program was introduced on a pilot basis in East Los Angeles to provide medical benefits for low-income families not eligible for Medi-Cal benefits. The plan provides coverage for outpatient physician services to families with annual gross incomes between 100 and 200 percent of the FPL. Although not a part of MediFAM coverage, White Memorial Medical Center provides hospital services and outpatient surgeries through a special arrangement with Blue Cross of California. Monthly premiums range from $42 for an adult and one child to $83 for a family. For child-only coverage, the monthly premiums range from $20 for 1 child, $33 for 2 children, and $45 for 3 or more children. Participants also pay a $5 to $15 co-payment for services. To date only 100 members have enrolled in the program which was targeted to serve about 3,000 members each year. MediFAM officials relate this low enrollment to marketing challenges, the program's cost in relation to the target community's income, and cultural barriers (92 percent of the target community is Latino).

IDEAS FROM ACROSS THE COUNTRY FOR COMPLETING THE JOB

With the creation and passage of the federal SCHIP legislation, states across the country have moved forward to provide affordable health care insurance to uninsured children. Some states are ahead of the game, having implemented innovative programs for children years ago, while others are using the opportunity of SCHIP to expand coverage to children for the very first time. As we look for ways to make sure all of California's children are insured, it is instructive to review some of the ideas being put forward by other states that could be useful here.

EXPANDING COVERAGE ABOVE 200 PERCENT OF THE FPL

The SCHIP legislation stipulates that a state can use its funds to provide coverage to uninsured children up to 200 percent of the FPL or up to 50 percent higher than pre-SCHIP Medicaid income levels, where this would carry the program over 200 percent of the FPL. However, two states received early approval from the Health Care Financing Administration (HCFA) to provide coverage to children up to 300 percent of the FPL. Connecticut and Missouri received federal approval by implementing an income disregard, which basically allows a state to disregard certain income when calculating a family's eligibility. Connecticut's HUSKY plan, for example, disregards income between 235 percent and 300 percent of the FPL. According to federal officials, this disregard option is fairly open-ended for states as written in federal law. A number of other states including Vermont, New Hampshire and Rhode Island are submitting plans to HCFA for approval which would also utilize an income disregard to serve children above 200 percent of the FPL.

Even prior to SCHIP, however, a handful of states including Massachusetts, Minnesota, New Jersey, New York, and Tennessee had already expanded coverage to children above 200 percent of the FPL through Medicaid expansions or state-funded programs.

ALLOWING FAMILIES TO BUY INTO PUBLIC COVERAGE

A number of states, in looking at ways to provide health coverage to children in families with higher incomes, found that many such families were unable to afford or obtain coverage. As a result, some states have allowed families with higher incomes to enroll their children in their state plan by paying the full premium. Existing buy-in programs include:

Buy-In Health Care Programs for Children: A National Review

State Program	Eligibility	Enrollment	Cost	Special Issues
Florida Healthy Kids	above 200% of FPL, no upper limit (was above 185% pre-SCHIP)	18% of overall enrollment	average cost of $54/month per child	limit buy-ins to 10% of total program enrollment (post-SCHIP)

Massachusetts Children's Medical Security Plan	above 400% of FPL, no upper limit	322 (or 1% of 25,232 post-SCHIP total enrollment)	about $52.50/month per child	.
New Hampshire Healthy Kids	300-400% of FPL (discussing whether to lift limit)	pre-SCHIP, about 1,700 (above 185%)	about $90/month per child (post-SCHIP)	post-SCHIP most children formerly in buy-in program will now receive some subsidy
New York Child Health Plus	above 222% of FPL, no upper limit	less than .5% of overall enrollment	$70 to $90/month per child	.
Tennessee TennCare	above 400% of FPL, no upper limit	N/A	$184.75 to $225.00/per month per person (same price child & adult); other prices for families	.
Texas Healthy Kids	above 185% of FPL, no upper limit	N/A	N/A	enrollment began 8/15/98
Washington Basic Health Plan	above 200% of FPL, no upper limit	16,861 adults and children (approx. 5,000 children)	$52 to $118/month per child	.

Sources: Anne K. Gauthier and Stephen P. Schrodel, "Expanding Children's Coverage: Lessons From State Initiatives in Health Care Reform" (Alpha Center: May 1997); Interviews conducted by The Children's Partnership.

States with experience in operating buy-in programs have generally found them to be politically popular because they require a family to be fully responsible for their coverage. However, their success depends in part on how expensive the coverage is and on how heavily the state markets its program.

Florida Healthy Kids Corporation operates a successful buy-in program historically comprising 18 percent of the overall program's enrollment. It offers affordable, quality coverage to children. It has been heavily marketed, ensuring that any risk was spread and adverse selection minimized. And, the buy-in program has helped deflate any

stigma attached to the state's subsidized program. With the expansion of Florida Healthy Kids under SCHIP, the state capped its buy-in at 10 percent of enrollment, reflecting insurers' stated concerns over adverse selection and their concern that the state program could eat into their commercial market.

In contrast, Washington operates a buy-in program, which has not reached many children. The Basic Health Plan is generally marketed for family coverage or adult individual coverage, and its rates sometimes exceed those available in the open market. In addition, it relies on private plans to market the program, though they tend to prefer to enroll people directly, rather than through Basic Health Plan.

EXPANDING SCHIP COVERAGE TO FAMILIES

While the main focus of our efforts is on expanding coverage to children, we would be remiss if we did not point out the important connection between children, their parents and health coverage. Studies show that the health and well-being of children is dependent on that of their parents and that a child is more likely to be enrolled in coverage if the entire family is eligible. A recent study by Tulane University found children are less likely to be uninsured when other family members are also eligible for Medicaid coverage.

The SCHIP legislation does allow for the purchase of family coverage but only in a very narrow set of circumstances. The law stipulates that the funds can be used to purchase family coverage for uninsured parents as well as their uninsured children so long as the state can prove that such purchasing is cost-effective and does not substitute for coverage that would otherwise have been provided in the employment-based system. A handful of states including Minnesota, Wisconsin and Massachusetts submitted proposals for providing family coverage under SCHIP. Although federal authorities have not released any written interpretation of the law, they have signaled that they take the law to mean that the family coverage must be the same price or less than the child coverage in order to qualify. According to federal officials, the only way to currently meet the requirements of the SCHIP law is to implement an employer buy-in, thereby using the employer contribution to offset the extra costs for family coverage.

Massachusetts' plan for doing just that was recently approved by federal authorities. Under the plan, the state will use its SCHIP funds to create the Family Assistance Plan for children with family incomes between 150 and 200 percent of the FPL. Families with uninsured children in that income category will be eligible for financial assistance to purchase family coverage through their employers. This program is coordinated with a similar premium assistance program which serves childless adults under a Medicaid 1115 waiver.

The plan anticipates enrolling 38,000 children and 23,000 of their parents, along with 85,000 childless adults. For those funded by SCHIP, the plan will pay its subsidy directly to the family after having received confirmation that the family is enrolled in the employer plan. Families will pay no more than 5 percent of their incomes for coverage (no more than $70 per month for those at 200 percent of the FPL). Employers will be required to pay at least 50 percent of a family's premium. The state will cover all income-eligible families, even if they currently have insurance, as long as the program's other requirements are met.

On the other hand, Wisconsin's plan, which sought to use SCHIP funds to cover parents directly rather than funding an employer buy-in program, was recently denied by HCFA. HCFA informed Wisconsin that it would have to use SCHIP funds to cover adults through an employer-buy in. In addition, HCFA informed Wisconsin that if it chose to cover both parents and children through Medicaid with SCHIP enhanced federal matching rates, then it could not cap the program to subvert the entitlement status for beneficiaries.

Crowd-out: The Good, The Bad and The Ugly

Crowd-out is the term used to describe employers or employees substituting private health coverage with public health coverage. Since a majority of individuals with higher incomes have insurance coverage through the workforce, the higher a public program goes up the income scale in terms of eligibility, the more concern there is that crowd-out will occur. Research on the impact of crowd-out includes:

- Three national studies resulted in widely different estimates of the effect of Medicaid expansions in the late 1980s on crowd-out. One study estimated a crowd-out effect that is quite large (50 percent of new Medicaid enrollment), one estimated an effect of 14 percent and the other found no effect.72

- Studies of Florida's Healthy Kids program and MinnesotaCare found that only 1 to 4 percent of enrollees had prior private insurance.73

- A survey of employers currently offering dependent coverage found that only 7 percent would eliminate such coverage if their employees' dependents were eligible for public programs.74

- Crowd-out is less of an issue when the coverage expansion focuses on children as opposed to programs targeting low-income adults.75

Crowd-out affects one specific group: those whose employers offer dependent coverage and the family is utilizing that coverage. The concern surrounds whether that family or that employer will quit contributing premium payments for employment-based coverage because of the availability of public funding. Most likely this would occur only if the family or the employer would receive a significant cost savings from doing so. Even if the public program were somewhat cheaper, inertia or the desire to keep the entire family under a single plan might prevent families from shifting their children for a small price advantage.

While it should come as no surprise that some small employers operating on the margin and low-wage employees struggling to pay high premium health coverage for dependents will opt for lower cost public programs, there are specific strategies that states administering publicly-funded child health insurance programs have implemented to reduce this potential. One such strategy is to require that children be uninsured for a specific period of time prior to enrolling into a public program. However, such waiting periods should be weighed against the heavy burden they could potentially place on families, particularly those with a child who has a chronic illness or disability. California currently has a 3 month waiting period for enrollment into Healthy Families.

Another strategy California undertook was to amend labor codes to provide financial penalties for employers who drop dependent coverage or reduce benefits packages in order to encourage employees to opt for public funded programs, and to provide financial incentives to employers who continue providing such coverage.

FORCES OF CHANGE

There are a number of important initiatives underway in California and nationwide which can be built upon or replicated as strategies are developed to reach the remainder of the uninsured children in California. There are also a number of profound changes that are redefining the political and policy environment which need to be factored in as these new strategies are developed. These "forces of change" suggest that the climate is ripe for moving ahead in California and point to promising new directions.

Major Shifts in Health Care Delivery and Financing Are Encouraging Community Experimentation and Innovation

The information presented in this Strategic Audit is a reminder of how much innovation and experimentation are underway in health care delivery among cities, counties, health plans, associations, employers and others across California and the country. Whether it's San Diego County's efforts to move residents into purchasing pools to stretch dollars furthest, Connecticut's SCHIP coverage for children with incomes up to 300 percent of the FPL, CaliforniaKids' efforts to insure children who do not qualify for existing programs, San Francisco's attempts to consolidate funding in order to reach the uninsured, or the Kaiser Permanente Cares for Kids $100 million commitment to cover some of the low-income kids, there seems to be a readiness from many stakeholders to address this problem in creative ways. Any plan to cover the remainder of the kids ought to celebrate and build upon these entrepreneurial efforts. In other words, there is no one single strategy for how health care ought to be extended, but rather a set of steps that build on both the public and private efforts now underway.

Broader Developments in the Health Marketplace Are Helping Determine the Solutions

Several important trends in California's health care marketplace ought to guide the solutions for uninsured children. First, California's employer base, while an important contributor to health coverage, provides substantially less coverage than employers across the country (57.8 percent of coverage is employer based in California compared to 65 percent nationally).76 In addition, employees are increasingly declining dependent coverage even if offered by their employer because they cannot afford the premiums. Any reform package for children will need to assure continuation of employers' contributions (30 percent of health care spending in California comes from employers)77 while offering options to employees for dependent coverage that is truly affordable for families. Issues like preventing substitution of public funds for employer health dollars ("crowd-out"), targeting subsidies to working families otherwise unable to afford dependent coverage, and redistributing the cost sharing for employees in relation to their ability to pay must all be thoughtfully addressed.

Healthy Families Changes the Landscape

The launch of the Healthy Families program on July 1 of this year marks the most significant step taken since the enactment of Medi-Cal over thirty years ago to insure children in California. However, to make the goal of this initiative a reality, critical improvements need to be made in the existing program to strengthen outreach and simplify enrollment of eligible children and to make sure families can afford the cost sharing. Healthy Families is likely to be unsuccessful until these improvements are in place. Any reform effort to insure the last of the uninsured children must also make the Healthy Families program work effectively so it provides a strong base for insuring currently eligible as well as newly eligible kids.

Considerable Resources Are Now Available to Solve this Problem
California enjoys a tremendous asset as it goes about the job of insuring the remainder of uninsured children. An estimated $858 million a year in federal funds are specifically earmarked for California through SCHIP. Unlike many other pressing needs in the state where the solution depends primarily on state and local resources, federal funding exists today to complete most of the job. In fact, federal funding will pay for almost two of every three dollars needed to insure kids. Under the SCHIP program, California is only required to provide a state match of 34 percent.

Equally important, the federal funds available to California each year must be spent within a specified amount of time. By the end of federal fiscal year 2000 (September 30, 2000), California must spend its three year allotment of approximately $2.577 billion (over $858 million allocated each year between FY 98 and FY 2000) or any remaining funds will become available to other states. California is far from meeting this target. To date, the state expects to expend less than $200 million of the federal funds by the end of fiscal year 1999. Even if the Healthy Families program is fully implemented in fiscal year 2000, California would only spend around $300 million in federal funds by the end of that year -- leaving roughly $2 billion to be reallocated to other states.78 Clearly, since California taxpayers have paid for their share of federal funding and the need exists among kids in the state, it would be short-sighted to allow our grant dollars to be used by other states.

In addition to the federal money available, substantial dollars will soon be available to cover California's state match as a result of its lawsuit against tobacco companies. In a settlement reached with cigarette makers, California is expected to receive $23 billion in funding over 25 years, or around $900 million a year. The proposed formula for the distribution of the funds is to allocate 50 percent to the state and 50 percent to counties and cities.79 Since the lawsuit recoups taxpayers' dollars for health care that had to be spent on health needs of smokers, there is a strong logic to spending it on addressing a pressing need in the state -- coverage for uninsured Californians.

California's Disproportionate Share of Kids Who Fall Through the Cracks
More than other states, California has large numbers of children who have no regular medical home or fall through the cracks of traditional insurance for some other reason. These include homeless children, kids whose parents are in the migrant worker stream, immigrant kids whose families came to California after August of 1996 (and therefore are not eligible for Healthy Families), and children in undocumented families. These children have the same needs as other children for treatment of common childhood ailments and for prevention and treatment of infectious diseases that can pose a public health threat. Whatever solutions are developed for children who do fit a traditional insurance model, California needs to ensure a strong public health safety net for the large numbers of kids who fall through the insurance cracks through no fault of their own.

There Is Bipartisan Interest and Support
Last summer, when federal SCHIP funding became available, Governor Wilson, advocates for children and families and the California Legislature worked cooperatively to design and enact the Healthy Families program. This bipartisan interest in and support for insuring California's children provides a strong foundation for moving forward. The new Governor and Legislature can build on the bipartisan precedent of Healthy Families to get the rest of the job done.

WHERE DO WE GO FROM HERE: THE 100% PLAN
NEXT STEPS AND RECOMMENDATIONS

As this Audit has shown, strong building blocks are already in place for reaching all of California's children with health coverage. Priorities for completing the job include recruiting eligible but uninsured children into Medi-Cal and Healthy Families, streamlining these programs so they really work for families, and then building on the public and private sector strategies now in place to reach the nearly 670,000 children who do not qualify for these programs. Our recommendations attempt to take into account the unique structure of California's health care system, the current political landscape and the unique characteristics of this group of kids and then to fashion a wise, coordinated plan that is achievable over the next three years.

In developing these recommendations for getting 100% coverage, we used several commonsense criteria. The recommendations are designed to:

- Help streamline existing and expanded health insurance programs so they are as simple as possible for families to use;

- Provide a solid foundation for the long-term, one to which other uninsured family members can be added;

- Leverage the greatest possible "bang for the buck" -- maximizing health care delivered for every dollar spent; and

- Build upon the areas of greatest consensus, thereby increasing the likelihood that the necessary actions will be taken.

Following is our recommended plan for providing coverage to California's estimated 1.74 million uninsured children along with our reasoning behind the plan. We hope the plan will serve as a useful resource and, by its specificity, spark discussion which can quickly lead to action. Over the next three years, the 100% Campaign is committed to moving forward on these recommendations and to working with other interested parties.

THE 100% PLAN: OVERVIEW OF RECOMMENDATIONS

The 100% Plan includes five core components:

1. Making Medi-Cal and Healthy Families work effectively for the over 1 million uninsured kids who are eligible but not currently enrolled;

2. Extending Healthy Families to the roughly 200,000 children in working families who cannot afford the full cost of insurance (those with annual incomes of less than $49,350 for a family of four);

3. Enabling families with higher incomes to buy affordable health coverage either through the Healthy Families purchasing pool or through other community-based and private sector solutions;

4. Shoring up the safety net for children who do not fit the traditional insurance model including homeless, migrant, and undocumented kids; and

5. Conducting a vigorous public education campaign for parents to underscore the value of getting insurance for their children and assist them in doing so.

We are also recommending critical research that needs to be undertaken to inform the decisions that policy makers and private sector leaders will make.

Detailed analysis of the cost of these recommendations needs to be carried out, and we are eager to work with California's Legislative Analyst's Office and others to do so. However, simple calculations reveal that there is ample money available today to get the job done well. If all of the estimated 670,000 remaining uninsured children were covered through Healthy Families (which we are not recommending, but is the easiest way to look at costs), the federal and state tab comes to roughly $600 million per year.80 This amount is in addition to the $485 million per year in federal and state funding officials estimate it will take to cover the 400,000 uninsured children currently eligible for Healthy Families.81 Clearly, with California leaving approximately $2 billion in federal SCHIP funding on the table through federal fiscal year 2000 and with $23 billion over 25 years in funding expected from the tobacco lawsuit settlement, there is more than enough money available to meet this challenge.82

We believe that with strong leadership from California's new Governor and Legislature the policy base for this plan can be put in place in the next two-year legislative session.

THE 100% PLAN FOR COVERING CALIFORNIA'S UNINSURED CHILDREN

<table>
<tr><th>Age</th><th>Up to 100% FPL</th><th>101-133% of the FPL</th><th>134-200% of the FPL</th><th>201-300% of the FPL</th><th>301% and above</th></tr>
<tr><td>< 1</td><td colspan="3">Medi-Cal</td><td></td><td>1. Buy-into Healthy Families at full-cost for children with parents:</td></tr>
<tr><td>1-5</td><td colspan="2">668,000</td><td colspan="2">Healthy Families
400,000
(current policy)
+
~ 200,000
(additional w/ expansion)</td><td>• transitioning between jobs; and
• who are self-employed or part-time workers.</td></tr>
</table>

MAKE HEALTHY FAMILIES AND MEDI-CAL WORK EFFECTIVELY

Californians should not underestimate how difficult it will be to make the current system work for the more than 1 million uninsured children who are currently eligible for insurance but unenrolled. Two formidable challenges are top priority: sustained and vigorous outreach in local communities across California to underscore the value of health insurance and recruit families into the programs; and a strong, clear statement from the Immigration and Naturalization Service (INS) allaying immigrant families' fears that using these programs will affect the parents' immigration status.

Beyond these very high pay-off measures, a series of additional steps are needed to simplify the enrollment process and create a coordinated, seamless children's health care system.

- Simplify the Healthy Families and Medi-Cal enrollment process. The difficult job of reaching out to the many low-income eligible but unenrolled children and their parents will be far more successful when enrollment impediments are removed. More specifically, we recommend the following measures:

- Shorten and simplify the Healthy Families/Medi-Cal joint application form. While state officials should be commended for their efforts to create a joint mail-in Healthy Families/Medi-Cal application, there still remains much to do to make the current 16 page application (which includes 12 pages of instruction) easier for families to use. A short form that is quick to complete is the key to an effective community-based outreach program because it would enable many more community-based organizations to participate in the states' outreach program, which gives community groups $25 for each family they help to enroll. California should follow the lead of Connecticut, which, like California, has two state programs for uninsured kids but uses a streamlined six-page joint application form (including instructions).

- Allow group eligibility determination. Since many low-income children have already been determined eligible for other programs in California based on their parents' income, Medi-Cal and Healthy Families eligibility workers could save countless hours and expense if these programs provided automatic eligibility to groups of children who have been means-tested by programs using similar

eligibility rules. Medi-Cal and Healthy Families should pilot the idea of giving automatic eligibility to groups of children receiving free or reduced price school lunches, the Supplemental Food Program for Women, Infants, and Children (WIC), or who attend Title I schools. Besides the cost savings in eligibility determination, this approach would help reach large numbers of needy children who have no coverage.

- Allow the same income deductions for Healthy Families that Medi-Cal uses. Healthy Families and Medi-Cal currently use different rules when counting income to determine eligibility. Medi-Cal uses a family's net income since that is the amount available for purchasing health insurance; deductions are calculated for child care, child support or alimony received, and work expenses. Under Healthy Families, these deductions are not allowed. These inconsistent income rules force many applicants to calculate their income using two different sets of rules which undermines the goal of a unified joint form. And, using the same rules for counting income in both programs would help to shorten the application form. Perhaps more important, using the simple approach of counting net income assures that families unable to afford coverage with their available income will be found eligible. The UCLA Center for Health Policy Research estimates that 48,900 additional uninsured children would be eligible for Healthy Families if the program were to use the same deductions as Medi-Cal .82

- Provide one year of continuous coverage and presumptive eligibility for the Medi-Cal program. While federal SCHIP law requires that children eligible for Medi-Cal not be enrolled in Healthy Families, several Medi-Cal rules make it more difficult for families and more costly for program administrators to certify eligible children for Medi-Cal and keep them certified. Rather than require families to file status reports and documentation every three months as is now the case, California should certify children for one continuous year, as the Healthy Families program does. Similarly, states can now allow children eligible for Medicaid to be determined presumptively eligible based on their stated age and family income. Adopting the federal option for presumptive eligibility in California would make it easier to reach the nearly 670,000 children who are eligible for Medi-Cal but not yet enrolled in the program.

- Ensure that the cost-sharing measures of the Healthy Families program are affordable to families. According to a recent cross-state comparison by the Children's Defense Fund, Healthy Families is charging families some of the highest premiums in the nation. Among the 32 states reviewed, California ranked 27th on the cost of premiums for children in families with incomes between 100 and 150 percent of the FPL.83 For many low-income working parents living from paycheck to paycheck, the cost-sharing required by the Healthy Families program may place it out of their reach. Feedback during the first six months of Healthy Families implementation on the impact the cost has on eligible families must be gathered and the cost-sharing requirements should be adjusted accordingly. This information will also help to determine what cost-sharing requirements other programs in California offering low-cost coverage to families should put in place.

Create a more coordinated and seamless children's health care system.
With children qualifying for different health programs in California depending on family income and the child's age, it is important to make the system as seamless as possible in order to assure coverage for as many children as possible. More specifically, we recommend the following measures:

- Increase outreach for Transitional Medi-Cal. An important opportunity is being missed for providing children and their parents with Medi-Cal coverage for up to two years. The Transitional Medi-Cal program is an important safety net which provides continuing Medi-Cal coverage for families as they move off cash assistance, frequently to low-wage jobs that do not provide health insurance. However, with only an estimated 10 percent of individuals eligible for the program actually applying for it, there needs to be increased outreach and application assistance so families know of its availability.84

- Expand Healthy Families coverage to recent legal immigrant children. Children who entered the country legally after August 22, 1996 are not eligible for Healthy Families during their first five years -- although legal immigrant children in the country prior to this date are eligible. Clearly, children who arrived in California after August of 1996 are just as much in need of health insurance as those who arrived several months earlier. A similar change in eligibility has already been made for Medi-Cal eligible children. State funds would be required to fund this expansion unless federal law is changed. The UCLA Center for Health Policy Research estimates that by the year 2001, 40,000 children could be affected by this measure.85

- Allow emancipated youth to apply to the Healthy Families program. The Healthy Families legislation was written in such a way that an emancipated youth who is under age eighteen cannot apply on his or her own behalf or on his or her child's behalf (a teen parent must be age eighteen or over to apply to the program for a child). Simply cleaning up this language would go a long way to ensuring easier to access the program.

- Implement the Healthy Families employer buy-in so it fully meets the needs of families. The employer buy-in (using SCHIP funding to subsidize coverage for an uninsured child through the parents' employer plan) has the potential to shore up employer-based coverage while allowing family members to use the same health plan. However, several measures should be put in place to ensure that the employer buy-in feature fully meets the needs of families.

First, in order to maintain employer dollars in health coverage and leverage the federal SCHIP funds to the maximum, the employer buy-in should expect the employer to contribute at least 50 percent of the premium. Second, the state should establish a system in which a slate of health plans in California are certified as meeting the benefit levels and cost-sharing guidelines used by SCHIP. If an employer offers a different insurance package but uses a carrier that provides one of the SCHIP-certified plans, the state could pay the difference to the carrier for extending the more comprehensive SCHIP-certified plan to the child. The state should also offer at least one of these plans through its HIPC, making it easier for small business owners to utilize the program.

In addition, the state should ensure that there is an administrative mechanism in place to track family co-payments, to ensure families are notified when they have reached the $250 annual family cap. Last, the state should direct the subsidy to the health plan rather than the employer or the individual in order to cut down on the possibility of crowd-out by the employer or the individual possibly having to provide the money up-front.

As California policymakers consider the option allowed under federal SCHIP law of using program funds to cover parents of eligible children, this employer buy-in can be built upon, as was done in Massachusetts, to help insure parents as well as their children.

EXTEND HEALTHY FAMILIES TO CHILDREN IN WORKING FAMILIES WHOSE PARENTS CANNOT AFFORD THE FULL COST OF INSURANCE

The Healthy Families program is a sound base to build upon to expand coverage to other uninsured children. There are three principal reasons: first, it will be simplest for families (whose income circumstances change frequently) to use one program rather than a patchwork of different programs; second, because the program offers families a choice among private health plans it avoids the stigma of welfare and is likely to be attractive to working families; and third, significant federal dollars are available at a two-to-one federal-state match to cover these children via the Healthy Families program.

The next logical building block is to extend Healthy Families to children with family incomes above 200 and up to 300 percent of the FPL. Expanding the Healthy Families program to cover children from families with incomes up to 300 percent of the FPL would reach almost half of the 400,000 uninsured children with family incomes too high to qualify for Healthy Families today. Such an expansion would cost roughly $179 million per year ($63 in state funds, $116 in federal).86

Using 300 percent of the FPL as a threshold makes good sense for several reasons. An expansion to this level would address a large part of the unmet need while still concentrating on families whose monthly budgets are tight enough that they need some assistance purchasing health coverage (annual income of less than $49,350 for a family of four). In addition, concentrating on this income group minimizes some of the concerns around crowd-out which occurs with higher income families.

And last, as was previously discussed, federal authorities have signaled their willingness to allow states (including Connecticut and Missouri) to use their SCHIP funding to provide coverage to uninsured children in families with incomes up to 300 percent of the FPL through the use of income disregards.

Even for this population of children, however, careful policies will need to be in place to ensure that Healthy Families dollars are actually used to cover currently uninsured kids and do not simply substitute for employer-provided coverage. The employer buy-in discussed previously should be implemented for this income group of children to help maintain employer-based coverage. In addition, ways in which employers can be successfully motivated to provide a financial contribution to Healthy Families for covering dependent children should be fully explored.

In addition to building upon the Healthy Families program for children, the parents of these children cannot be forgotten. Common sense suggests, and a few preliminary studies show, that parents are more likely to sign up their kids for health coverage if that

coverage is also available to them. Thus, it seems important for the well-being of the children to offer comparable Healthy Families coverage to parents. Since the SCHIP law allows for family coverage under certain circumstances and since sufficient funding is available, California ought to examine this option further, including the possibility of implementing an employer buy-in for parents, as we previously discussed.

ENABLE FAMILIES WITH HIGHER INCOMES TO BUY AFFORDABLE COVERAGE (THROUGH THE HEALTHY FAMILIES PURCHASING POOL OR THROUGH OTHER COMMUNITY-BASED AND PRIVATE SECTOR SOLUTIONS)

The challenge in addressing the situation for families with incomes above roughly $50,000 annually for a family of four (300 percent of the FPL) is how to offer them the chance to buy into affordable coverage while not undercutting the employer market which many people in this income group are already part of and which contributes 30 percent of the health care spending in California.87 We are suggesting several strategies that target currently uninsured children and enable parents to buy affordable coverage for their children. These include buying into the Healthy Families purchasing pool, along with other community-based and private sector solutions.

Allow families above 300 percent of the FPL to buy into Healthy Families.

The Healthy Families purchasing pool offers a unique opportunity to provide families with no coverage the ability to buy a comprehensive benefit package at a lower cost than they could find on the private market. It is estimated that the Healthy Families program costs a total of $74.75 per month per child or $897 a year.88 For a married couple with two children and a family income at 300 percent of the FPL, the cost of coverage would represent 3.6 percent of their income; at 400 percent of the FPL it would represent 2.7 percent of income. This strategy can become a win-win as it makes coverage affordable to families who have none and brings a new market to health plans which might not otherwise be able to recruit families in this income range. The success of this idea will depend on vigorous marketing of the Healthy Families product.

Since the buy-in program would focus on families with higher incomes, it is extremely important to structure the program in a way that will not lead to an erosion of the employer market. We recommend targeting this opportunity on several specific high need populations. They include children with parents who are:

- between jobs, who qualify for COBRA but may have trouble paying the required amount;
- self-employed; and
- part-time workers.

Build on private sector strategies.

Since the majority of children above 300 percent of the FPL have parents who are employed, considerable efforts should be made to work with health plans, businesses and others in the private sector to make health insurance more accessible and affordable to these working families and their children. Steps include:

- Encouraging health plans, health systems and physician groups to provide and/or market low-cost products and subsidized coverage. Building on some of the innovative programs described in this Audit, we encourage more plans,

health systems and physician groups to follow the lead of San Diego's Community Health Plan, Kaiser Permanente Cares for Kids, Brown & Toland Medical Group and others piloting innovative ways to use private sector resources to reach more of the uninsured. Child-only plans also offer considerable potential as another vehicle for families to obtain health insurance for their children. Health plans should market these plans to families, and health outreach efforts should inform parents of this low-cost option.

- Work with businesses, associations and other organizations to promote increased and affordable dependent coverage and to provide resources for subsidized coverage. Considerable interest exists and much can be done through the small business community and professional associations to pool purchasing and develop low-cost products that members want and can afford. For example, the California Small Business Association has been interested in testing out the market for a low-cost child-only product. Necessary market research for such initiatives should be supported so groups known to have large numbers of uninsured children might use their collective purchasing power to develop and market needed new products for children.

- Support the development and expansion of purchasing cooperatives at the state and local level. Purchasing pools including Pacific Business Group on Health, the HIPC, and county initiatives such as the early efforts in San Diego and San Francisco offer the potential for expansion to other groups (and in some cases individuals) seeking affordable insurance. As these grow, they could offer families who have been shut out from affordable insurance for their children important new sources of access to dependent coverage.

- Support the development and expansion of community-based efforts and philanthropic solutions. As this Strategic Audit demonstrates, a number of activities across the state are already providing coverage to uninsured children within local communities. If the Healthy Families program is expanded to reach children with family incomes up to 300 percent of the FPL, these community-based solutions can be redirected to serve the remaining kids. However, too often these programs are not widely known in the communities they serve. We hope that this Strategic Audit is the first step in informing people about existing voluntary programs in California and sharing models that can be replicated in other communities.

SHORE UP THE SAFETY NET FOR CHILDREN WHO DO NOT FIT THE TRADITIONAL INSURANCE MODEL

California, with a disproportionately large number of children who are homeless, in the migrant stream, or undocumented, has always had special arrangements for children who do not fit the traditional health insurance model. The safety net, which consists of community and county clinics and hospitals, needs to be preserved and strengthened, especially now that many of the insured patients whose financing helped defray the costs for uninsured kids are moving into managed care plans. The number of uninsured children who will continue to turn to the safety net is substantial even with existing programs. Without making extra efforts to reach out to these children, California will continue to face high incidence of costly but preventable emergency room visits as well as serious risks to public health.

To protect the public health and ensure that the health needs of California's children are met, several steps should be taken. First, the programs that currently provide services to these hard-to-reach children should be shored up financially, including the Child Health and Disability Prevention Program (CHDP) and Early Access to Primary Care (EAPC). In addition, with 50 percent of the tobacco settlement funds being allocated to counties and cities, we recommend that health coverage for these safety net kids be a priority for spending the money and that a Safety Net Fund be created through which to do so. Moreover, community-based and private sector programs that have been providing care to uninsured children with incomes of less than 300 percent of the FPL can redirect these resources to safety net kids as Healthy Families steps up to insure the children these programs formerly served. Finally, targeted outreach in immigrant and migrant communities should refer families to these safety net providers and let them know that use of these health services will not affect their immigration status.

CONDUCT A VIGOROUS PUBLIC EDUCATION CAMPAIGN URGING PARENTS TO GET HEALTH COVERAGE FOR THEIR CHILDREN

California's experience with Medi-Cal and Healthy Families makes clear that offering health insurance to 100% of children will not assure that all these children actually get coverage. So, while our recommendations will make affordable insurance available to all children, additional steps must be taken to educate parents about the value of enrolling in a plan and using services.

This kind of public education will be challenging. For some families it is extremely difficult to dip into the tight family budget to purchase coverage; others, because of cultural beliefs, are fearful of western medicine or of immigration authorities; others are simply juggling so much between work and parenting that they have put off the less urgent things to do including getting health coverage; still others are confused by the various programs and choices available and opt to hold off for awhile.

A sustained public education effort with the same kind of reach and "buy in" as "don't drink and drive" is needed to motivate families to avail themselves of the health plans available. The campaign should also help families learn how to obtain coverage. The whole range of stakeholders from employers to health plans to schools to government to the entertainment sector have important roles to play in carrying out this public education campaign. It is vital that it be a multilingual effort and that it particularly target the hard to reach families including, for example, immigrant communities, teen parents and the unemployed.

CLOSING THE RESEARCH GAP

In researching and writing this Audit, it became clear that certain missing information must be gathered in order to develop sound plans for insuring the remainder of children in California. Following are the key research questions that ought to be answered to ensure that California's resources are most effectively allocated.

What Is Affordable Coverage for Families? As we outlined in the Audit, one of the biggest challenges to developing health coverage solutions for uninsured children is determining what is affordable coverage for working families. Only limited analysis has been done on this subject to date, and cost-sharing levels for existing programs have been established with no real knowledge of what is appropriate for families at different income levels. This information becomes especially important as families with incomes

over 200 percent of the FPL are added to Healthy Families since some level of cost-sharing is expected from these families. One useful place to start is with the experience of families responding to the cost-sharing rules in the Healthy Families program. A statewide survey and/or focus groups of families can build on this early Healthy Families experience.

What Motivates a Family to Obtain Health Coverage for Their Children? One crucial piece of missing information is why a family does or does not obtain health coverage for kids. The answer to this question will help guide how best to structure outreach efforts and design insurance programs for uninsured children. This information becomes especially important as insurance is made available to families with higher incomes. As plans move forward to reach 100% coverage, focused research is needed to learn: What marketing strategies would influence a family to buy coverage for their children? What do families look for in a health insurance plan (i.e. access to providers, cultural sensitivities, travel distance, etc.)? This information would best be gathered through a statewide survey and/or focus groups.

Is there a health care market for low-cost child or family products? Before moving forward in the private sector to develop and market low-cost health insurance products, certain market analysis needs to be completed. Key questions include: Is there a market for low-cost products? What are the demographics of the buyers? What would families or employers be willing to pay to purchase it?

A FINAL WORD

The goal of providing 100% of California's kids with health coverage is, indeed, achievable. More than enough funding is available to get the job done. What's required now is for the various stakeholders to work together in unprecedented ways toward this common goal -- government, health plans, elected officials, employers, schools, the insurance industry, the entertainment community, parents, faith communities and many others.

As a first step, we urge policymakers, health players, and employer groups to come together around this 100% Plan. Top priorities are to "fix" the problems with existing health coverage programs for kids and then to build up the income scale, offering affordable coverage through Healthy Families and the private sector. The last critical piece is to mount the aggressive outreach and public education campaign necessary to motivate parents to enroll their kids in health care intuitively, as they do for school. With hard work, we believe this simple but ambitious goal can be attained in three years. The 100% Campaign looks forward to working with all interested parties to make 100% coverage a reality for California's children.

APPENDIX A: ENDNOTES

1 University of California, Berkeley and the UCLA Center for Health Policy Research, The State of Health Insurance in California, 1997, January 1998; and Paul Fronstin, Sources of Health Insurance and Characteristics of the Uninsured, Employee Benefit Research Institute, December 1997. Both figures based on calculations of the March 1997 Current Population Survey.

2 The numbers of currently uninsured children in California used in this report represent those children who were uninsured prior to the implementation of the Healthy Families program and the expansion of the Medi-Cal program. As of September 5, 1998, 11,648 uninsured children have been enrolled in Healthy Families. The numbers in this section are from the UCLA Center for Health Policy Research, analysis of the March 1997 Current Population Survey, 1998. For the methodology see Appendix D.

3 UCLA Center for Health Policy Research, analysis of the March 1997 Current Population Survey, 1998.

4 Age groups are: younger than 5; 5-12; 13-18.

5 Includes the counties of Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Los Angeles.

6 Anglo is defined as non-Latino white.

7 Margaret Edmunds and Molly Joel Coye, eds. America's Children: Health Insurance and Access to Care, Committee on Children, Health Insurance and Access to Care, National Research Council and Institute of Medicine, 1998.

8 A number of studies have shown that children without health insurance are less likely to have a usual source of care, are less likely to be immunized and receive well-child care. Besides those listed in this report they include: J.D. Kasper, "The Importance of Type of Usual Source of Care for Children's Physician Access and Expenditures," Medical Care, vol. 25, no. 5, 1987; M.L. Rosenbach, Insurance Coverage and Ambulatory Medical Care of Low-Income Children: United States, 1980, National Center for Health Statistics, Public Health Service, U.S. Department of Health and Human Services, 1985; D.C. Leftkowitz and P.F. Short, Medicaid Eligibility and the Use of Preventive Services by Low-Income Children, presented at the 1989 Annual Meetings of the American Public Health Association in Chicago, Il.

9 J. Stoddard, R. St. Peter, and P. Newacheck, "Health Insurance Status and Ambulatory Care for Children, New England Journal of Medicine, 330(20), 1994, pp. 1421-25. Based on data from the 1987 National Medical Care Utilization and Expenditure Survey (NMCUES).

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11 Ibid.

12 M. Susan Marquis and Stephen H. Long, "The Uninsured Access Gap: Narrowing the Estimates," Inquiry, Vol. 31, Winter 1994/95, pp. 405-414. Based on data from the 1987 NMCUES.

13 K. Finkelstein, "Insuring Children: Health Care Reform Writ Small," The Nation, March 3, 1997, p. 18.

14 Elizabeth Shenkman, Enrollees' Health Care Use and Regular Source of Care in the Florida Healthy Kids Program, Institute for Child Health Policy, Jan. 1997.

15 California Department of Health Services, California Children's Health Plan, August, 1997.

16 Summary information gathered from health plans by The California HealthCare Foundation and The Children's Partnership.

17 Sources of Health Insurance and Characteristics of the Uninsured, op. cit.

18 UCLA Center for Health Policy Research, op. cit.

19 The Alpha Center, tabulations of the March 1991-1997 Current Population Surveys, 1998.

20 UCLA Center for Health Policy Research, op. cit.

21 Sources of Health Insurance and Characteristics of the Uninsured, op. cit.

22 The State of Health Insurance in California, 1997, op. cit., pp. 36 and 37. Data obtained from a 1997 KPMG-UCLA Employer Benefits Survey of 1,068 firms with 3 or more employees.

23 The Lewin Group, Recent Trends in Employer Health Insurance Coverage and Benefits, 1996, pp. 13-16.

24 United States General Accounting Office, Employment Based Health Insurance, February 1997, p. 18.

25 UCLA Center for Health Policy Research and KPMG, Trends in Job-Based Health Insurance Coverage, June 1998, p. 21-26. Another reason for the low take-up rate cited in the report is the trend by employers to offer less choice in health plans.

26 Paul Ginsburg, "Tracking Small-Firm Coverage, 1989-1996" Health Affairs, Jan/Feb. 1998.

27 Employment Based Health Insurance, op. cit., p. 13. Data source from the Bureau of Labor Statistics.

28 Ibid., p. 6.

29 Ibid., p. 10.

30 Trends in Job-Based Health Insurance Coverage, op. cit., p. 26. Cost varies by plan type, HMO, PPO or conventional.

31 Lewin-VHI, Inc. The Financial Impact of the Health Security Act, December 9, 1993.

32 Leighton Ku and Teresa Coughlin, The Use of Sliding Scale Premiums in Subsidized Insurance Programs, The Urban Institute, Washington, D.C., March 1997.

33 Trends in Job-Based Health Insurance Coverage, op. cit.

34 Assumes 40 hours per week for 50 weeks per year for the following occupations: Shipping and receiving clerk @ $8.75 / hour ($16,100); Custodian @ $10.45 / hour ($20,900).

35 1997 Fair Market Rent for a 2-bedroom is $787. CA FMR is average FMRs weighted by the number of renter households in each area, from Center on Budget and Policy Priorities.

36 At-home food consumption based on US Department of Agriculture's Low Cost Plan for two adults and two children ages 3 and 7 (December 1997).

37 1996 average cost of full-time child care for child, 3 years and part-time for child 6 years old (assumes in school) in Sacramento County at a child care center, California Child Care Resource and Referral Network.

38 Transportation costs based on half the average cost to operate one car that is more than 10 years old and has 100,000 miles. Estimate includes fuel, tires, repair, insurance and taxes, and had been converted to 1998 dollars using the Consumer Price Index (John E. Schwartz, Illusion of Opportunity, 1997).

39 Based on 1997 California and Federal income taxes (including Social Security, Medicare and California Disability). Assumes parents are married and filing jointly. Federal calculations completed by the Internal Revenue Service.

40 The State of Health Insurance in California, 1997, op. cit., pp. 8-10; and The Alpha Center, op. cit.

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42 The State of Health Insurance in California, 1997, op. cit., p. 37.

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44 Ibid.

45 Jill Yegian, James Robinson and Ann Monroe, Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience, The California Healthcare Foundation, May 1998, p. 22

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47 Ibid., p. 1.

48 Interview with the Managed Risk Medical Insurance Board, September 1998. Calculations based on the number of individuals insured in the small group market (about 4 million).

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50 Information provided by the Managed Risk Medical Insurance Board, 1998.

51 UCLA Center for Health Policy Research, op cit.

52 Because certain types of income are not counted towards total family income, families with higher gross incomes may still qualify for Medi-Cal.

53 Medi-Cal Policy Institute, Transitional Medi-Cal Fact Sheet, 1998.

54 UCLA Center for Health Policy Research, op. cit.

55 Interview with Managed Risk Medical Insurance Board, August 31, 1998.

56 Robert Fellmeth, California Children's Budget 1998-99, Children's Advocacy Institute, 1998.

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58 Ibid.

59 Ibid., p. 4/31.

60 Interview with Sunni Burns, Chief, Primary and Rural Health Care Systems Branch, California Department of Health Services, August 25, 1998.

61 Phone conversation with Licensing and Certification, California Department of Health Services, August 25, 1998.

62 Venice Family Clinic Fact Sheet, 1998.

63 California Budget Project, Budget Watch, April 1997, p. 8.

64 Ibid.

65 Ibid.

66 The State of Health Insurance in California, 1997, op. cit., p. 8.

67 Ibid., p. 10.

68 U.S. General Accounting Office, Health Insurance for Children: Private Individual Coverage Available But Choices Can Be Limited and Costs Vary, August, 1998.

69 Ibid; and through interviews conducted by The Children's Partnership.

70 Interview with Dave Coons, Blue Cross Health Plan on August 27, 1998.

71 Health Insurance for Children: Private Individual Coverage Available But Choices Can Be Limited and Costs Vary, op. cit.

72 David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" Quarterly Journal of Economics 111(2), May 1996; Lisa Dubay and Genevieve Kenney, "The Effects of Medicaid Expansions on Insurance Coverage of Children," The Future of Children 6(1), Spring 1996; E. Yazici, Medicaid Expansions and the Crowding Out of Private Health Insurance," paper presented at the 18th annual Research Conference of the Association for Public Policy Analysis and Management, Pittsburgh, PA, November 2, 1996.

73 K.T. Call, et al., "Who is Still Uninsured in Minnesota?: Lessons for State Reform Efforts." JAMA 278(14):1191, October 8, 1997; Elizabeth Shenkman, et al., The Florida Healthy Kids Program: Are There Indications of Crowd-out? Institute for Child Health Policy, Gainesville, Florida, September 1997. Florida's program only requires an eligible child to be uninsured, with no firewall, and Minnesota's program requires an eligible child to be uninsured for four months.

74 Harriette Fox and Margaret McManus, The Potential for Crowd-Out Due to CHIP: Results from a Survey of 450 Employers, The Maternal and Child Health Policy Research Center, Fact Sheet Number 3, March 1998.

75 The Alpha Center, "Expanding Coverage Without Attracting the Already Insured," State Initiatives in Health Care Reform, November 1997, pp. 7-9.

76 The State of Health Insurance in California, 1997, op. cit., pp. 8-10; and The Alpha Center, op. cit.

77 Lucien Wulsin, California at the Crossroads: Choices for Health Care Reform, Center for Governmental Studies, 1994.

78 1997-98 and 1998-99 California Budgets; Legislative Analyst's Office, Major Expenditure Proposals in the 1998-99 Budget, 1998; California Department of Health Services, California Children's Health Plan, August 1997; and Health Care Financing Administration, Notice dated September 12, 1997, 62 Federal Register 48098, updated October 3, 1997. Computations by The Children's Partnership: California is expected to receive over $858 million for each fiscal year FY 98, FY 99 and FY 2000 or a total of $2.577 billion by the end of FY 2000. Full implementation of the Healthy Families program is expected to cost $485 million ($315 in federal funds and $170 million in state funds). However, it is expected that California will spend $200 million in federal funds by the end of FY 1999. If the Healthy Families program was fully implemented in FY 2000, the total expenditure in federal funds would be around $500 million ($200 million in spending up to FY 1999 plus $300 million in spending for FY 2000 full implementation). Thus, by the end of FY 2000 California would have roughly $2 billion in funding remaining.

79 Henry Weinstein, "Formula Set Up to Divide State Tobacco Suit Funds," Los Angeles Times, August 8, 1998.

80 Computations by The Children's Partnership of the number of uninsured children not eligible for Medi-Cal or Healthy Families (670,000) multiplied by the yearly cost of coverage ($897) under Healthy Families. This figure does not include possible administrative costs the state could incur.

81 Full implementation of the Healthy Families program for currently eligible children is expected to cost $485 million ($315 in federal funds and $170 million in state funds). See: California Department of Health Services, California Children's Health Plan, August 1997. We have not included figures for the uninsured children eligible for Medi-Cal because the cost of insuring the vast majority of these children are already financed with Medi-Cal dollars.

82 1997-98 and 1998-99 California Budgets; Legislative Analyst's Office, Major Expenditure Proposals in the 1998-99 Budget, 1998; California Department of Health Services, California Children's Health Plan, August 1997; and Health Care Financing Administration, Notice dated September 12, 1997, 62 Federal Register 48098, updated October 3, 1997. Computations by The Children's Partnership: See endnote 79.

83 Steven Wallace, Lucien Wulsin, Carolyn Mendez and Richard Brown, California's Options to Expand Health Insurance Coverage, UCLA Center for Health Policy Research, May 1998.

84 Stan Dorn, Gregg Haifley and Jeannette O'Connor, CHIP Check-Up: A Healthy Start for Children, Children's Defense Fund, May 12, 1998.

85 Transitional Medi-Cal Fact Sheet, op. cit.

86 California's Options to Expand Health Insurance Coverage, op. cit.

87 Computations by The Children's Partnership of the yearly cost of the Healthy Families program per child ($897) multiplied by the roughly 200,000 children who would be eligible. Note: this figure does not include possible administrative costs the state could incur.

88 California at the Crossroads: Choices for Health Care Reform, op. cit.

89 California Children's Health Plan, op. cit.

APPENDIX C: PEOPLE INTERVIEWED FOR THIS REPORT

Ingrid Aguirre Happoldt, Medi-Cal Policy Institute
Carmella Bocchino, American Association of Health Plans
Bruce Bronzan, Institute for Health Futures
Trisha Brooks, New Hampshire Healthy Kids
E. Richard Brown, UCLA Center for Health Policy Research
Helen Bryan, Health Economics, New York Department of Health
Luisa Buada, California Institute for Rural Health Management
Sunni Burns, California Department of Health Services, EAPC Program
Beau Carter, Integrated Health Care Association
Carmela Castellano, California Primary Care Association
Molly Coye, The Lewin Group
Kathy Crompton, Seacoast HealthNet
Susan Crystal, State of Washington Governor's Office
Richard Curtis, Institute for Health Policy Solutions
Bob Di Prete, Oregon Health Plan Policy and Research Office
Angie Dombrowicki, Wisconsin Department of Health and Family Services
Mary Donnelly-Crocker, Pasadena's Young & Healthy
Soap Dowell, Managed Risk Medical Insurance Board
Sylvia Drew Ivie, THE Clinic for Women
Ann Eowan, Association of California Life and Health Insurance Companies
Richard Figueroa, Senate Committee on Insurance
Fred Fisher, Washington Medical Assistance Administration
Celia Gaytan, Latino Issues Forum
Michele George, Washington Health Care Authority
Mary Griffin, Mary Griffin & Associates
Mary Jo Grubbs, San Diego Community Health Group
Kris Haltmeyer, Blue Cross/Blue Shield Association
James Harper, Citywide Central Insurance Program
Claudia Harrison, MediFAM
Scott Hauge, San Francisco Small Business Network
David Helms, Alpha Center
Miya Iwataki, Los Angeles County Department of Health Services
David Kears, Alameda County Health Services Agency
Lee Kemper, California Center for Health Improvement
Jana Key, Florida Healthy Kids Corporation
Paula Kiger, Florida Healthy Kids Corporation
Michael Koch, CaliforniaKids Healthcare Foundation
Linda Kotis, Kaiser Permanente Cares for Kids
Marianne Kuecher, Physician Business Health Plan
Marlene Larson, National Health Foundation
Laura Lawlor, Texas Healthy Kids Corporation
Jeff Lazenby, Sharp Health Plan
Philip Lee, Institute for Health Policy Studies
Lawrence Lewin, The Lewin Group

Burt Margolin, Brady & Berliner
Denise Martin, California Association of Public Hospitals and Health Systems
Barbara Masters, California Association of Public Hospitals and Health Systems
David Maxwell-Jolly, California Senate Committee on Appropriations
Angie Medina, Los Angeles County Department of Health Services
Nancy Monk, PacifiCare
Ann Monroe, California HealthCare Foundation
Yolanda Partida, San Diego County Health and Human Services
Margaret Peterson, California Department of Health Services, CHDP Program
Carolyn Polokowski, National Coordinating Council of Caring Programs
Pat Powers, Pacific Business Group on Health
John Ramey, Provider Choice
Mark Reynolds, Massachusetts Division of Medical Assistance
Mary Richards, Venice Family Clinic
Lourdes Rivera, National Health Law Program, Inc.
Marty Savalos, Center for Medicaid and State Operations, HCFA
Bob Scarlett, Blue Cross/Wellpoint
Helen Schauffler, University of California at Berkeley, School of Public Health
Margo Schramm, Physicians' Business Partnership
Mark Sektan, California Association of Health Plans
Sandra Shewry, Managed Risk Medical Insurance Board
Arthur Southam, Health Net
Steve Thompson, California Medical Association
Betty Jo Toccoli, California Small Business Association
Kirsten Varnau, Brown & Toland Physicians Services
Paul Wallace-Brodeur, Office of Vermont Health Access
Bill White, Center for Child and Family Health, RIteCare
Lucien Wulsin, Office of Lucien Wulsin
Jill Yegian, California HealthCare Foundation
Lisa Yoder, Community Health Group

APPENDIX D

STATISTICAL METHODOLOGY FOR "UNINSURED CHILDREN: PUTTING THE CHALLENGE IN CONTEXT"
(PRESENTED BY THE UCLA CENTER FOR HEALTH POLICY RESEARCH)

The March 1997 Current Population Survey (CPS) was used to develop the estimates of uninsured children in this report as presented on pages 11 and 12. The U.S. Census Bureau, which conducts the CPS every month, interviews in person and by phone using a rotating sample of approximately 55,000 households. The March CPS, used in this study, collects data on more than 14,000 individuals in California. The March CPS includes questions that ask whether each person in a household was covered at any time during the preceding year by health insurance from any private or public source, with separate questions for each category of coverage. Respondents to the March 1997 CPS were thus asked about coverage during calendar year 1996. Persons covered by any source at any time during the preceding year were counted as insured. The remaining populations are those with no private or public third-party coverage and are considered uninsured. The eligibility estimates are based on the AFDC definition of poverty.

The CPS includes a number of discrete questions asking whether each person has a particular type of coverage during the year. The UCLA Center for Health Policy Research created a single hierarchical variable with priority given to employment-based insurance (a group health plan through an employer); then to private insurance (coverage that is not through an employer and is privately purchased); then to Medicaid; then to Medicare; and finally to CHAMPUS/VA (Veterans Affairs)/military. Finally, those who reported no coverage from any source are considered uninsured. The CPS yields fairly precise estimates of insurance coverage for large groupings within the state because the sample size in California is very large. Analyses of subgroups are less precise because the smaller numbers of respondents in sample subgroups make population estimates for these subgroups subject to more error.

A special data run was also obtained for this project from Enrico Marcelli at the University of California, San Diego, who imputed the documentation status of all adults in the 1997 CPS using data from his 1994 study of Mexican immigrants in Los Angeles County. Using the profile of unauthorized entrants from his study,

based on their age, sex, education, and years in the U.S., he assigned approximately 2.1 million adults as undocumented in California. The UCLA Center for Health Policy Research then assigned children as undocumented if either parent was undocumented and the child was a non-citizen. These methods created an estimate of approximately 500,000 undocumented immigrant children, 19% of the total estimated undocumented population for California. This proportion is lower than the 25% estimate used by the U.S. General Accounting Office. However, if the INS estimate of 2 million total undocumented residents in California in October 1996 is used, the working estimate of the number of undocumented children is consistent with commonly used figures.

APPENDIX F

EMPLOYMENT-BASED STRATEGIES	SUMMARY	REFERENCED IN AUDIT ON PAGE
Sharp Health Plan 800-82-SHARP	Administers FOCUS, a two-year demonstration model targeting uninsured small business employers (with 2-50 employees). Provides subsidized health coverage for employees, their spouses and dependents.	18
Community Health Group (CHG) 619-422-0422	A San Diego-based HMO. Launched a commercial product in October 1997, which focuses on low-cost health plans for businesses that do not offer insurance to employees.	19
Adecco, Inc. 650-610-1000	An international temporary employment agency offering a cafeteria style purchasing pool for employees. Employees must work a minimum of 20 hours per week for 8 consecutive weeks in order to participate.	19

Hotel and Restaurant Employees Union (HERE) 310-451-9701	Provides health care coverage for part-time employees who are union members. The union tracks and banks employees' hours to ensure continual coverage.	19
Motion Pictures and Television Fund (MPTF) 888-558-4247	Provides health coverage to individuals in the entertainment business and their families through a preferred provider network.	19
PURCHASING STRATEGIES	**SUMMARY**	**REFERENCED IN AUDIT ON PAGE**
Pacific Business Group on Health (PBGH) 415-281-8660	A purchasing pool of thirty-four private and public sector large employers with at least 2,000 benefit-eligible employees. Also includes the subsidiary, Negotiating Alliance, which represents twenty-one employers in negotiating rates, benefits and performance measures with health plans. PBGH represents nearly 3 million lives.	20
CalPERS 916-326-3000	A purchasing pool that is available only to public employers. It has developed standard health benefit plans and operates its own self-insured plan.	20

	CalPERS covers about 1 million lives.	
Western Growers Association (WGA) 714-863-1000	Provides low-cost health insurance to full-time, part-time and seasonal workers in the agricultural business. The Association concentrates recruitment efforts in rural areas where workers are most likely to be uninsured. Does not offer child-only coverage.	20
Health Insurance Plan of California (HIPC) 800-HIPC-YES	A statewide purchasing cooperative which negotiates price and benefits with carriers for small business employers (7,400 firms as of April 1998). Employers are required to contribute 50 percent of premiums for the lowest cost employee-only plan.	21
PUBLIC SECTOR STRATEGIES	**SUMMARY**	**REFERENCED IN AUDIT ON PAGE**
Medi-Cal 916-657-1460 Benefits 916-654-9162 Eligibility	Primary funder of health care for low-income children in California. Eligibility is mostly based on a family's income: under 1 year old below 200% of the FPL; 1-5 years old below 133% of the	22

	FPL; 6-18 years old below 100% of the FPL.	
Healthy Families 888-747-1222	Provides subsidized health care coverage to uninsured children of low-income working families who are ineligible for Medi-Cal, but are at or below 200% of the FPL.	23
Access for Infants and Mothers (AIM) 916-324-4695	A subsidized health insurance program for pregnant women and their children up to age two years of age with family incomes of 200 up to 300% of the FPL.	25
California Children's Services (CCS) 916-654-0499	Serves low-income children with serious medical problems. Children must have a family income of no more than $40,000 or an anticipated medical expense greater than 20% of the family income.	26
Child Health Disability And Prevention Program (CHDP) 916-654-0364	Provides regular immunizations and medical assessments to children eligible to receive Medi-Cal, non-Medi-Cal eligible children up to age 19 and young children in Head Start and state preschool programs. Treatments prescribed as a result of medical assessments are	26

	also provided.	
Expanded Access to Primary Care (EAPC) 916-654-0348	Provides annual funding to primary care clinics that provide preventive health care to medically underserved individuals with incomes below 200% of the FPL who do not have third-party health or dental coverage.	26
INNOVATIVE LOCAL STRATEGIES	**SUMMARY**	**REFERENCED IN AUDIT ON PAGE**
San Diego County 619-515-6588	Currently exploring ways to aggregate public patient care dollars including Medi-Cal, indigent care and Healthy Families into a single local purchasing entity to provide coverage to uninsured San Diegans.	28
City & County of San Francisco 415-554-2626 or 2631	Proposed a plan for pooling funding spent for employee and retiree medical coverage with federal and state health care funds in order to provide coverage to uninsured individuals in San Francisco, including part-time workers, college students and	28

	unemployed adults.	
Young & Healthy (Pasadena, CA) 626-795-5166	A volunteer physician program which provides free medical services to uninsured children in Pasadena who are not eligible for Healthy Families through a network of volunteer physicians, dentists, optometrists and other health care professionals.	29
Kids Stay Healthy 415-776-5140	A plan being developed by Brown & Toland Medical Group to create a network of providers to cover the health care needs of uninsured children above 200% FPL in the San Francisco area. Slated to begin in January 1999.	29
INDIVIDUAL COVERAGE STRATEGIES	**SUMMARY**	**REFERENCED IN AUDIT ON PAGE**
CaliforniaKids 800-374-4KID	Provides subsidized health care coverage for children ages 2 through 18 (including undocumented and emancipated youth) who are not eligible for Medi-Cal, Healthy Families or enrolled under any private health care plan. Premiums for	31

	the over 200% of the FPL.	
Kaiser Permanente Cares for Kids 800-255-5053	Provides subsidized health care coverage for uninsured children with family incomes between 200 and 275% FPL. The program is expected to serve 50,000 children over 5 years.	32
MediFAM 800-903-0300	Offers coverage for low-income families in the Boyle Heights area of Los Angeles who are not eligible for Medi-Cal. Both family and child-only coverage available.	32

APPENDIX G

CHILD-ONLY PRODUCTS OFFERED BY
CALIFORNIA INSURERS 1

BLUE CROSS OF CALIFORNIA/WELLPOINT HEALTH NETWORKS
800-777-6000

CaliforniaCare HMO Plans*		
Age of Child	**CA Care Plan**	**CA Care Saver Plan****
0 to 1	$79-84 / month	$64-68 / month
1 to 18	$66-70 / month	$53-56 / month

* Each plan has a $10 co-payment.
** $1,500 annual deductible applies to specific services, such as hospitalization.

Benefits: Physician office visits, preventive care, well-baby care, hospitalization, emergency care, and prescription drugs.

BLUE SHIELD
800-734-2442

Access+ HMO

Age of Child	High Option Plan*	Value Option Plan**
0 to 1	$93-129 / month	$77-106 / month
1 to 4	$60-77 / month	$49-63 / month
5 to 18	$54-62 / month	$40-51 / month

* Has no deductible and no charge for hospital care (except for pregnancy delivery)
** Has a $1,500 deductible for most hospital services with no charge for inpatient care after deductible has been satisfied.

Benefits: Preventive physician office visits, emergency services, hospitalization, vision and hearing screenings, well-baby and well-child care, and prescription drugs.

CIGNA HEALTH CARE OF CALIFORNIA
VIBA 800-248-8422 (Broker for CIGNA Individual Plans)

HMO Option	
Age of Child	**$15 / $150 Co-Pay Plan***
0-18	81.48-89.49/ month (includes $6 adm. fee)

* $15 co-payment for routine doctor visits, and $150 hospital co-payment per day for a maximum of $750 per admission.

Benefits: Preventive care, well child care, routine immunizations and injections, laboratory and x-ray, specialty physician services, inpatient hospital services, emergency care and prescription drugs.

FOUNDATION HEALTH PLAN
800-909-3447

HMO Advantage		
Age of Child	**HMO Advantage 7***	**HMO Advantage 10****
0 to 1	$110-191 / month	$96-176 / month
1 to 4	$72-105 / month	$64-98 / month
5 to 18	$60-89 / month	$53-82 / month

* Has a $7 co-payment.
** Has a $10 co-payment.

Benefits: Office visits, surgery and hospital services, well-baby care, speech and hearing evaluations, physical exams, immunizations, outpatient services, emergency care, and laboratory services.

KAISER PERMANENTE
800-464-4000 Southern CA
800-489-9918 Northern CA

Age of Child	Personal Advantage*
up to age 2	$64 or $71
3 to 18	$45 or $52

* Premium based determined by region (Southern or Northern).

Benefits: Office visits, routine physicals, hearing and vision examinations, well-baby care, alcohol and drug dependency services, mental health services, prescription drugs, and hospitalization.

PACIFICARE OF CALIFORNIA
800-577-0001

Individual HMO Plan	
Age of Child	**HMO 10**
under 1	$96-109 / month
1 to 18	$73-82 / month

Benefits: Physician office visits, emergency care, hospitalization, newborn care, well-baby care, periodic health evaluations, laboratory services, and prescription drugs.

<1> This is not a comprehensive list of insurers providing health coverage in California. The information was collected from health plan brochures and telephone inquiries compiled by the California HealthCare Foundation and The Children's Partnership. Some companies also offer additional individual plans with higher co-payments and deductibles. This overview presents only a limited summary of benefits.

APPENDIX H

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