Proposal
Healthy Kids is a proposed expansion of health insurance coverage for children ages 0 to 5 living in Los Angeles County below 300% of the federal poverty level (FPL) who are not eligible for Medi-Cal or Healthy Families. Commission funds will be spent to cover the costs of the approximately 15,000 eligible children age 0-5. Funding partners will be sought to cover the costs of insuring the approximately 112,000 older children through age 18 who would eligible for Healthy Kids.

Benefits will be similar to Medi-Cal and Healthy Families. Coverage will include comprehensive ambulatory care including preventive care, vision and dental care, prescription medicine, mental health services and substance abuse treatment, emergency room and inpatient care.

Healthy Kids will either be administered by the local administrator of the Medi-Cal managed care initiative for Los Angeles County, as was done in the other Counties who have adopted the Healthy Kids model, or a plan administrator identified through an RFQ or other process.

The projected, total yearly cost to the Proposition 10 Commission for Healthy Kids is $18.9 million annually. This cost includes the coverage for children, outreach and marketing, a hardship fund to assist families in paying premiums, and an evaluation. This proposal recommends that the Commission make a five-year funding commitment to Healthy Kids of $100 million with the remaining $1.1 million each year to be used for quality improvement and other needs identified as the initiative develops.

We recommend that additional program enhancements be included as next steps of this initiative, including coverage for parents, quality of care enhancements, addressing provider supply issues, and an electronic medical record.

Background
Learning comes easier to a healthy child. Health problems, such as asthma, poor vision, or dental problems, interfere with learning. Physical and mental health problems cause children to miss school, lack energy, be distracted, or have other problems that impair their ability to learn.

Significant scientific effort has been made to establish links between health and student performance. For instance, general absenteeism has been linked to lower school achievement, and chronic illness-related absenteeism was linked to even lower school achievement\(^1\). Tooth decay is the single most common chronic childhood disease

accounting for more than 51 million school hours lost yearly\textsuperscript{2}. Teachers and researchers are in agreement: teachers in urban areas estimated that 18% of students (more than 1 in 6) have emotional or physical health problems that hinder their school performance\textsuperscript{3}.

Access to health care is essential to ensure that our children stay healthy, receive the preventive care they need, and are ready for school, and having health insurance is key to promoting access to care. A recent study showed that compared to insured children, uninsured children were:

\begin{itemize}
  \item eight times less likely to have a regular source of care,
  \item 2.8 times less likely to have had a recent visit with a physician,
  \item four times more likely to delay seeking care,
  \item six times more likely to have gone without needed medical, dental, or other health care\textsuperscript{4}.
\end{itemize}

Having a regular source of care promotes continuity of care, predicts the use of preventive services, and can thereby decrease the use of emergency and specialized services. Children that do not have access to health insurance are less likely to seek care. Those that do not seek care are more likely to be ill, and children that are ill perform poorly in school. However, health insurance programs like those we will discuss shortly can make a difference. In one study, 12 months after enrollment 99% of children had a regular source of care and 85% had a regular dentist. Unmet need or delayed care in the previous six months decreased, and the percentage of children seeing a physician increased. The proportion of children using emergency services for care also decreased\textsuperscript{5}.

New data from the California Health Interview Survey (CHIS) indicate that there are approximately 382,000 uninsured children in Los Angeles County. Of these uninsured children, 76,000 are aged 0-5. According to a report issued by UCLA's Center for Health Policy Research, Los Angeles County's rate of uninsured children is 28% higher than California's overall rate, and the county is home to 37% of the State's uninsured. In fact, these numbers are likely higher today given that conditions may have worsened since the CHIS study was conducted (early in 2001). Unemployment has grown over the past year and the county's rate of poverty is nearly 30% higher than that of the state overall.

In recent years, several California counties developed programs to expand health coverage beyond Medi-Cal and Healthy Families. For instance, Santa Clara developed

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\textsuperscript{2} Community Partnerships for Healthy Children Spotlight, \textit{The Statistical Facts of Dental Health} (Sacrament0, CA, Sierra Health Foundation, August 2000), p. 6.
the Healthy Kids program to approximate universal health coverage for children. This program provides comprehensive health benefits to all children up to age 18 living in families below 300% of the Federal Poverty Level (FPL). San Francisco County is also implementing the Healthy Kids model. San Mateo County developed a similar expansion that will cover children 0-5 up to 400% FPL, and funding partners have been identified to cover children to age 18. Alameda County developed a plan to provide subsidized family care for parents and siblings of Healthy Families children.

The Healthy Kids programs in Santa Clara and San Francisco and the health coverage expansion in San Mateo all are supported by their local Proposition 10 Commissions. In fact, the San Mateo commission has made a 10 year funding commitment to their local expansion project.

The Santa Clara County Healthy Kids model serves as the basis for this proposal and has several key strengths:

- The model provides comprehensive health coverage for children,
- The coverage level is comparable to Medi-Cal and Healthy Families—siblings eligible/enrolled in different programs will have similar coverage, thereby reducing confusion about what are and are not covered services,
- The model has been implemented in Santa Clara and San Francisco with successful results,
- Adopting the model in Los Angeles County may create momentum resulting in adoption of this or other models of near universal child health insurance coverage across the state of California.

**Core Proposal Details**

**Eligibility**

Health insurance coverage for children is currently provided in a patchwork fashion, with different programs covering children depending on age and income. Healthy Kids will fill a gap in the patchwork by raising eligibility for publicly sponsored coverage to 300% FPL.
Healthy Kids will cover uninsured children:

- Between the ages 0 to 18, with Proposition 10 funds covering children through age 5
- Living in families with incomes below 300% FPL
- Ineligible for Medi-Cal or Healthy Families
- Whose parents can provide proof of Los Angeles residency (for example: Driver's license, California ID card, utility bills, or rental agreements)

In Los Angeles County, there are an estimated 15,000 children ages 0-5 who will qualify for Healthy Kids. An additional 112,000 children aged 6-18 meet the eligibility requirements, and will be eligible pending identification of a funding source for this population.

By covering children up to 300% FPL, 96% of all uninsured children in the county age 0-5 will be eligible for some type of health insurance. There will remain slightly more than 3,000 uninsured children 0-5 who live in families with incomes above 300% FPL. However, restricting eligibility to children under 300% FPL was chosen to avoid crowd-out, which could occur if Healthy Kids was perceived as more appealing than employer-based programs and people began to substitute Healthy Kids for employer-based coverage.

**Coverage**

Benefits are similar to Medi-Cal and Healthy Families. Healthy Kids covers comprehensive ambulatory care, including preventive care, inpatient care, vision care, dental care, prescriptions, mental health services, and substance abuse treatment.
One goal of universal coverage for children is that families should not experience a big difference whether their child is eligible for Medi-Cal, Healthy Families, or Healthy Kids, and that as family status changes, family members can move among programs with minimal disruption.

Costs to Families
Monthly premiums for families will be comparable to Healthy Families, at about $4 - $6 per child per month, with discounts provided for advance multi-month payments. There should be no co-pays for preventive services such as well child care or immunizations to encourage the use of these services. There will be modest co-pays for other services such as emergency room usage and prescription medications.

The modest premiums and co-pays are intended to keep the program similar to Healthy Families and to avoid crowd-out. If Healthy Kids had no costs to the families, the program would be more attractive than employer-based insurance, which generally has co-pays.

A “hardship fund” will be established to provide premium assistance for families at risk of losing coverage because of non-payment of premiums. The amount of money in this fund will be modest in the first year, based on the low utilization in other jurisdictions that have established such a fund. Los Angeles County’s experience in the first year will determine the allocation for future years. The initial hardship fund allocation will be based on the experience of other counties as well as our experience with disenrollments from Healthy Families due to non-payment of premiums.

Administration
Two alternatives would be considered to administer Healthy Kids. One option would be for LA Care, Los Angeles County’s Medi-Cal managed care local initiative, to administer the program. The advantage of using this initiative is that it may be able to offer families the same health plans or providers that they offer Medi-Cal and Healthy Families recipients, thereby creating a more seamless system for families that may have children eligible for different programs. In addition, LA Care already has an established infrastructure for administering a major health coverage program, and can incorporate quality improvement efforts into plan administration. Finally, LA Care may choose to contribute its own funds toward the Healthy Kids program, to offset Proposition 10’s costs or to expand the program beyond the 0-5 population.

Another alternative would be to conduct a Request for Proposals to select a health plan.

Outreach and Enrollment
Outreach efforts are critical to the success of Healthy Kids. Eighty percent of the 76,000 uninsured children ages 0-5 are eligible for Medi-Cal or Healthy Families but are not enrolled. Families cite many barriers to enrolling, but two commonly cited barriers are that families are not aware of the programs or that they did not realize they might be eligible. A major outreach and marketing initiative must be undertaken once Healthy Families is launched to familiarize people with the program and to develop name
recognition. This outreach initiative will also result in increased enrollment in Medi-Cal and Healthy Families, since some of the families targeted by Healthy Kids outreach will actually be eligible for other programs.

Outreach and enrollment strategies will include:

Work with DPSS to gain support for Healthy Kids, so that Medi-Cal Eligibility Workers can also assist with Healthy Kids applications.

Many Eligibility Workers have been outsourced to community sites so that families do not have to travel to DPSS offices to apply for health benefits. When these workers identify children eligible for Healthy Kids, they should have the training necessary to assist families in submitting Healthy Kids applications.

Coordinate Healthy Kids outreach with existing Medi-Cal and Healthy Families outreach and develop new, innovative approaches.

Community-based agencies currently conduct broad-based outreach as well as work one-on-one with families to resolve barriers to enrolling and accessing services. This approach is effective not only in enrolling children, but also in ensuring that children retain their coverage. While existing outreach efforts will include Healthy Kids in the range of options they present families, additional outreach efforts will be needed, particularly since State funding for Healthy Families outreach has been targeted for major cuts in the May revise of the State budget. In addition to community-based agencies, Certified Application Assistors also help families in completing Healthy Families applications and could be trained on Healthy Kids as well. Best practices….

Partner with schools

Schools also play a critical role in outreach because they have ready access to eligible children and their parents. Implementation of Assembly Bill (AB) 59, Express Lane eligibility, will link eligibility for the free and reduced cost school lunch program to eligibility for Medi-Cal. Although the May revise to the state budget indicates that implementation may be delayed, outreach efforts in schools should continue with an eye toward eventual implementation of AB 59.

Conduct “inreach” among existing providers’ service populations

In addition to outreach to new populations, DHS and other safety net providers will conduct “inreach” by screening patients in their own medical facilities for Healthy Kids eligibility, as they currently do for Medi-Cal, Healthy Families, and other programs.

Ensure simplicity in the application and enrollment process

Simplicity of the application will be key to increasing the percentage of eligible families that apply. Complexity of the application has frequently been cited as a barrier to applying. In addition, the application should be non-threatening, with no reference to immigration status.

Yearly payment option with significant discount
San Francisco County had considerable success avoiding retention problems by offering the option to pay monthly premiums up front on a yearly basis with a 25% discount. At $4 per month, the yearly premium before the discount would be $48. Following the discount, enrollees pay only $36. San Francisco County felt that the $12 cost to the program from reduced premiums was money well spent because it helped reduce any insurance retention problems that may have arisen if enrollees paid on a monthly basis. The majority of the enrolled population has selected the prepayment option, and although the program is only six months old, no one has been disenrolled for non-payment of premiums.

Evaluation
A program evaluation will be conducted to address the extent to which:

- Healthy Kids is successful in enrolling eligible children,
- children retain coverage over time,
- the concept of universal health coverage for children is understood by families,
- the availability of universal health coverage for children has resulted in a spillover effect of increasing enrollment in Medi-Cal and Healthy Families,
- enrolled children access medical and dental providers,
- improved health outcomes result from expanded health insurance and outreach efforts.

Program Costs
Based on local experience with Medi-Cal and Healthy Families as well as the experience of other counties, Healthy Kids is estimated to cost between $75 and $86 per child per month. The annual cost of premiums for all 15,000 eligible children 0-5 will be between $13.5 million and $15.5 million.

It is unlikely that the maximum cost estimate will be incurred in the first year, since not all eligible families will choose to enroll their children and it will take time to ramp up the project to enroll the majority of eligible children. In Los Angeles County, 85% of eligible children 0-18 are estimated to be enrolled in Medi-Cal and 57% are estimated to be enrolled in Healthy Families. However, the fact that Healthy Kids is not a “government program” or “welfare program” might lead to a higher acceptance rate. Unwillingness to enroll in a “welfare program” is often cited by eligible families as a barrier to enrolling in Medi-Cal. Santa Clara estimated that 50% of the eligible population enrolled in the 18 months that the project has been implemented and San Francisco estimated that 25% of the eligible population has enrolled after only 6 months.

During the first year the Commission expects that there will be a need to spend significant funds on outreach and marketing. Since full enrollment will not be achieved in the first year, unspent funds for premiums will be directed toward outreach and marketing. Staff anticipate that as much as half of the funds dedicated for first year premiums may be directed to first year outreach and marketing, as has been the case in San Francisco. Based on current experience with contracting for outreach and enrollment services for health insurance programs in Los Angeles County, a minimum of $2,000,000 is allocated for yearly outreach beyond the first year.
Potential Funding Partners
The Commission’s funds can only be directed at costs for children age 0 to 5. Funding partners will be identified for other age groups and may include:

- Assembly Bill 495 – The Los Angeles County Department of Health Services and LA Care submitted a concept paper to MRMIB seeking funding for Healthy Kids for children 6-18 between 250-300% FPL.
- Medicaid Administrative Assistance--Federal matching funds for outreach at 50% of eligible costs
- Targeted Case Management -- Federal matching funds for outreach/case management at 50% of eligible costs
- The entity that administers Healthy Kids
- Foundations
- Other public funding sources
- A Proposition 10 Trust Fund where funding allocated to the health insurance initiative can be stored and collect interest to help sustain Healthy Kids in future years

In addition, the State of California ranks low among other States in terms of its Medicaid billing levels. The Commission will investigate potential efficiencies that might make additional funds available.

Funding from partners will be sought to address insurance coverage for children outside of the Commission’s target population. Funding may also affect the amount of Commission funds needed for the program. For instance, if Medicaid Administrative Assistance matching funds are received, the need for Commission funds directed toward outreach might decrease.

Cost Summary
The following table summarizes the core proposal costs for the first three years of the program:

<table>
<thead>
<tr>
<th>Program Element</th>
<th>Estimated Yearly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year One</td>
</tr>
<tr>
<td>Premiums</td>
<td>8,750,000</td>
</tr>
<tr>
<td>Outreach/Marketing</td>
<td>8,750,000</td>
</tr>
<tr>
<td>Hardship Fund</td>
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<tr>
<td><strong>Subtotal</strong></td>
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</tr>
<tr>
<td>Evaluation*</td>
<td>900,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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</tbody>
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*Evaluation funds would be budgeted within a different funding category.
What is needed to make it work?
The California counties that have expanded or are currently expanding children’s health coverage have shared the lessons they learned from their experiences. The following principles have been included in this proposal or will impact implementation:

- Commitment and buy-in is needed from government officials and legislators, parents, teachers, and other community members. These groups disseminated information to families and communities, helped with enrollment, and provided continued outreach to ensure that families were accessing health services.
- Public/private partnerships are an essential component to successful implementation.
- The labor movement and faith-based organizations played key roles in organizing, legislative advocacy, and research.
- Media support was instrumental to success. Once the project’s feasibility was established, the press was a key ally and helped to influence public officials to support the project.
- The most successful Counties had active community advisory boards that provided feedback on issues such as quality, potential expansions and innovations, cultural competence in outreach, program design, and retention efforts.

Recommended Program Enhancements
Simply opening a program that would allow additional children to become eligible for health insurance and attempting to enroll them may not be sufficient to resolve the uninsured child health problem in Los Angeles County. Optional program elements may be needed, could be added as the program develops, and might include the following.

- **Provide Health Insurance for Parents**
  Covering parents for children eligible for Healthy Kids is a logical extension of the program because parental health impacts the wellness and school readiness of their children. Parental coverage could cover a more limited benefit package, to avoid being cost-prohibitive. The California Kids program currently offers coverage to children ineligible for other programs; coverage is for outpatient services only. A “California Parents” program could offer outpatient service coverage to parents ineligible for other programs. In this scenario, as with the California Kids program, parents would have to receive inpatient care from safety net providers.

  Based on local costs for Medi-Cal and California Kids coverage, the cost for a benefit package for parents that excludes inpatient care is estimated to be about 45% of the costs for a full scope benefit package. An outpatient only benefit package is estimated to cost approximately $700 per parent per year. The number of parents to be targeted and the overall costs are yet to be determined.

  Expansion of Healthy Families to parents has been delayed as part of the May revise to the State budget. The expansion of coverage to parents for those parents whose children participate in Healthy Kids may want to also include expansion of coverage to those parents whose children participate in Healthy Families because:
the health of parents impacts children,
parents and families may be participating in or eligible for multiple programs,
as the complexity in individual programs is a barrier to enrollment and use,
complexity in the system may multiply the effects of this barrier.

Covering parents of children in Healthy Kids but not Healthy Families would leave those children whose parents do not have coverage at risk based on their parents’ unmet health needs, and create a confusing, incomplete patchwork of health insurance programs.

Incorporate a program to increase the quality of care provided by Healthy Kids, Medi-Cal, and Healthy Families medical practitioners.

Medical services are not the only factor in keeping families healthy. Access to high-quality services is crucial to ensuring better health outcomes for children.

Attempts to address quality can focus on multiple targets: the health plan, the care provider, the medical personnel, the patient, etc. The Commission will need to identify at which level(s) it should focus, as well as research further the current activities and best-practices for each level.

Approaches for incentivizing quality care at the provider level can take different forms. Financial penalties have been found to be unsuccessful, as providers simply opt-out of networks when faced with penalties. Financial rewards have been found to make no or only modest impact.

Approaches that have proven successful have targeted intervention at the provider level. One strategy has been system simplification, such as making it easier for providers to navigate a health plan’s regulations on prescription medicine. A provider may be faced with different requirements for preauthorization based on which of five benefit packages the patient is participating in. The complexities of navigating multiple plans can be difficult and inhibit quality in many ways. Ensuring that the provider can easily identify a plan’s requirements in this situation would go far to ensuring consistent quality.

Another strategy that has proven effective is providing feedback on opportunities for improvement based not at the health plan level but at the practice level. Providing quality assessments at the health plan level requires that providers take steps to identify if their practices contribute to the problem in the aggregate. Providing direct information about what could be improved at the provider level allows providers to focus on making needed internal improvements.

The Commission may seek to enhance the quality of care received by Healthy Kids enrollees by applying existing best-practices to the Healthy Kids plan and provider network. Assisting individual providers make improvements in provider-specific practice may lead to real change and real improvement in health care.
Whereas the above strategies largely focus on existing best-practices, the opportunity exists to promote the development of new best-practices. By establishing learning collaboratives that convene staff members from different disciplines within a primary practice (e.g. nurses, physicians, nurse practitioners, administration), new change strategies can be identified and implemented that would improve the quality of the care provided. For example, a change strategy could result in a method for tracking immunizations to reduce missed opportunities to immunize and avoid the potential problem of over-immunizing children due to incomplete immunization records.

- **Include a component and partner with other organizations to address health care supply issues**

This initiative is being developed in the broader context of the downsizing of the Los Angeles County Department of Health Services and a generalized crisis in the health care system being seen currently in the provision of emergency care. Although the Commission does not have the capacity or mission to sustain the public health infrastructure it can and should participate in the solution. The Healthy Kids program will create additional demand for health care services as those children who were previously uninsured become insured and attempt to make use of their insurance. The Commission should develop a program and/or work in collaboration with other funders to enhance the supply of services. For instance, the California Endowment recently expanded by $45 million its Community Clinics Initiative. The California Endowment’s total commitment to the initiative is now $98 million.

Additionally, the Commission will learn from the challenges faced by other counties and their implementation in Healthy Kids. Santa Clara County utilized an HMO dental care provider and found that the market incentives were insufficient to ensure sufficient supply. The San Francisco Healthy Kids program utilized a PPO for dental care to alleviate the problem faced in Santa Clara, but failed to include a requirement for a minimum number of providers in their contract with Delta Dental. Thus, they also experienced a supply shortage at the onset of their program. As a PPO, market incentives were sufficient to encourage Delta Dental to increase the numbers of providers to meet demand within months of the program’s implementation. The Los Angeles County should both utilize a PPO and include in the contract with the network a minimum number of providers that will be available to enrollees.

- **Develop an electronic medical record for participants**

Such a record would also address the immunization example above, and would also improve the quality of patient care by preventing duplication of services as well as

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6 The Community Clinics Initiative provides funding to plan and complete community clinic construction and renovation. Outcomes will include serving additional patients, assist business plan development, facility design, fund development, loan request preparation, debt planning, and resource/loan program coordination. Source: “Health Foundation Earmarks $45 Million to Improve the Capacity of Community Health Clinics.” California Endowment Press Release 6/18/02.
missed opportunities to provide preventive care due to fragmented services received at multiple facilities.