A Tale of Two Counties: Expanding Health Insurance Coverage for Children in California

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During difficult economic times, many California counties have expanded health insurance coverage for low-income children. These Children's Health Initiatives (CHIs) enroll children in public programs and provide new health insurance, Healthy Kids, for those ineligible for existing programs. This article describes the policy issues in implementing the Santa Clara and San Mateo County CHIs, as well as the children's enrollment levels and utilization of services. These CHIs are among the first of the thirty California counties planning or implementing such initiatives. Their success depends on leadership from county agencies that have not traditionally worked closely together, as well as the development of a diverse public and private funding base. This effort to provide universal coverage for all children is important to national policymakers desiring similar goals.

Keywords: Child health insurance, immigrant health, California.

As the nation continues to struggle with a growing number of uninsured people, the only bright spot is children. The State Children's Health Insurance Program (SCHIP), enacted in 1997, along with expansions of Medicaid in the 1980s and 1990s, led to fewer uninsured children at the same time that the number of uninsured adults rose (Bhandari and Gifford 2003; Hoffman, Carbaugh, and Cook 2004; Kenney, Haley, and Tebay 2003; Rhoades and Cohen 2003; Strunk and Reschovsky 2004).

Studies also show pronounced differences in access and use between children with and without health insurance (Holl et al. 1995; Stoddard,

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St. Peter, and Newacheck 1994), but SCHIP and the expansions of Medicaid have improved access to care and service use for newly insured children (Dick et al. 2004; Lave et al. 1998; Van Landeghem and Brach 2004). While the assumed relationship between increased availability of insurance coverage and the improved health status of children has not been demonstrated definitively, studies have shown a relationship for some populations (for reviews of this literature, see Hadley 2003; Starfield and Shi 2004).

Despite this progress, many children in the United States are still not insured. Since 1998 the greater number of immigrants into the United States has accounted for much of the growth of the uninsured (Fronstin 2005). In particular, immigrant children, especially Hispanic immigrant children, are far more likely to be uninsured than other children are. The greatest problem is that many such children are undocumented and therefore do not qualify for Medicaid or SCHIP (Capps et al. 2004). "Undocumented" children are those who are not residing in the United States legally, although children born in this country may be documented when their parents are not.

Even when children are eligible for public programs, immigrant parents face numerous barriers to enrolling them, such as lack of familiarity with insurance and limited proficiency in English (Alker and Urrutia 2004; Doty 2003; Fix and Capps 2002; Hughes et al. 2000; Reardon-Anderson, Capps, and Fix 2002; Weathers et al. 2004). In addition, many immigrant parents worry that enrolling their children might constitute a "public charge," thereby inhibiting their ability to obtain permanent residency (Perry, Stark, and Valdez 1998).

California's children face many of the same barriers to obtaining health insurance and adequate health care as do children across the nation (Grossman-Swenson and Dominguez-Arms 2004; Manos et al. 2001; Tomas Rivera Policy Institute 2002). Among California's uninsured children, 60.8 percent are documented and thus eligible for either Medi-Cal (Medicaid) or Healthy Families (SCHIP). The remainder are ineligible because of their documentation status or because their household incomes are too high (Brown and Lavarreda 2005). Although the state does not offer full public coverage to undocumented children, they are entitled to Emergency Medi-Cal for two months for medical emergencies and to preventive care through the Child Health and Disability Prevention Program.

Overview of Children's Health Initiatives

Because of the many children who are not entitled to existing public coverage or who are eligible but not enrolled, a growing number of counties in California are sponsoring new initiatives to increase health insurance coverage for children (California Endowment 2004; Gardner and Kahn 2004; Harper 2003; Testa et al. 2003). These programs, referred to as "Children's Health Initiatives" (or CHIs), have a two-pronged approach: the creation of a new insurance product for children ineligible for Medi-Cal or Healthy Families called "Healthy Kids," and a coordinated outreach and enrollment initiative using county agency outreach workers, community-based organizations, and schools to increase enrollment in Medi-Cal, Healthy Families, and Healthy Kids. At the time of this writing, eighteen counties had established CHIs, and another twelve were in the planning stage, expecting to begin operation in 2006.

The CHI approach, with its potential to cover virtually all children regardless of immigration status, suggests that it could be a model for other states with sizable numbers of uninsured children, particularly undocumented uninsured children. The CHIs are remarkable because they were funded and implemented during a period of economic distress. For these reasons, it is important to understand how the Children's Health Initiatives are faring and whether they offer lessons to other parts of the country.

In 2001 the David and Lucile Packard Foundation funded an evaluation of the Santa Clara CHI, and in 2003 San Mateo County funded an evaluation of its own CHI. Table 1 lists the key characteristics of these counties, two prosperous and primarily suburban counties just south of San Francisco. Santa Clara County is the larger one and has a higher rate of impoverished children (9.0 percent) than San Mateo does (6.5 percent). Santa Clara County began implementing its CHI in January 2001, and San Mateo County began in February 2003.[1]

The CHI evaluations included implementation analyses that examined the following questions:

- What are the principal components of the Children's Health Initiatives?
- How much does this program cost, and who funds it?

TABLE 1
Key Characteristics of Santa Clara and San Mateo Counties, 2000

	Santa Clara	San Mateo
Population size	1,678,421	697,456
Percent of population under age 19	24.7	22.9
Number (%) of children below poverty level	36,548 (9.0)	10,295 (6.5)
Unemployment rate	2.6	2.2
Percent of foreign-born population	34.1	32.3
Birthplace of foreign-born population (%)		
Asia	57.3	44.8
Mexico	24.4	22.2
Other Latin American countries	4.4	14.6
Other	13.9	18.4
Percent speaking Spanish at home	17.6	18.1
Percent of population below federal poverty level	7.5	5.8
Median household income ($)	74,335	70,189
Percent under age 65 uninsured at any time during last year (2001)[a]	13.8	12.1

Note: [a]Source is California Health Interview Survey (2001); information for children not available.
Source: U.S. Bureau of the Census, 2000.

- Does this program expand coverage and improve use of needed health services?
- Are there financial benefits for county health systems?

To explore these issues, we made three comprehensive week-long visits in 2001, 2003, and 2004 to Santa Clara County and two similar site visits in 2003 and 2004 to San Mateo County. During these visits, we interviewed numerous stakeholders, including county administrators, health plan administrators, enrollment assistors, advocates (e.g., from faith and labor organizations), health care providers, and others and also observed the outreach/enrollment process.[2] We also conducted more than one hundred personal interviews in both counties, using a semistructured protocol to elicit similar information for each year and county. Our notes summarized the findings from each site visit.

In addition we obtained aggregate data from several sources, the most important being enrollment trends and utilization in the county-sponsored health plans that enroll most of the publicly insured children in both counties.[3] We also looked at the enrollment process, trends in enrollment from each of the three public programs, and information about hospital use from the state and hospitals themselves.

Administering the CHIs

The Children's Health Initiatives are two-pronged efforts that offer both a new insurance program to those not eligible for other insurance and help to all uninsured children. When local stakeholders try to expand health insurance coverage for children in this way, they face several challenges. First they must establish a governance structure, either inside or outside the local government, to oversee the CHI's development and operation. But their greatest challenge is raising funds locally for the new insurance program and the outreach/enrollment activities.

Governance

Developing an appropriate governance structure is critical to implementing the initiatives quickly, maintaining flexibility as the initiatives grow, and overseeing the quality of services and accountability of funds. The Santa Clara and San Mateo CHIs' informal, collaborative governance structure includes diverse partners: public agencies (the county health and social service agencies), private foundations, the local government-sponsored managed care plans that administer the Healthy Kids programs, advocacy groups such as labor and an organization of faith congregations, and the "First 5" commissions. (These commissions administer revenues from a statewide tobacco tax of 50 cents per pack, with the funds used to promote the healthy development of children aged zero to five.) This lack of formality in governance has generally worked well in both counties and has not led to any major conflicts.

In both counties strong leadership and regular communication have helped overcome institutional barriers to enrollment. These local partnerships have helped work through operational details (e.g., who completes, receives, and processes applications) and sustain the public interest needed to raise money from public and private sources.

Neither CHI is administered by a formal nonprofit entity but instead by unincorporated partnerships that evolved during the planning phase and have remained stable throughout the initiatives' early years. The leadership is primarily from the public health plan in Santa Clara County and the public health agency in San Mateo County. The larger coalitions, which do not meet often, are primarily for information sharing and policy development, while smaller committees oversee the planning and implementation of the initiatives.

The health plans' close involvement in governance may seem unusual, since they receive premiums to provide insurance coverage for children. But because the plans function as public plans for the counties, they have oversight from the county boards of supervisors (the county legislative bodies). Consequently, the boards of supervisors can intervene if severe financial or operational problems arise.

Financing

Finding adequate financing for the CHIs has been a constant challenge, since most of the money has been raised locally during difficult economic times, even though these are relatively wealthy counties and have some sources not available elsewhere. For example, funds from two foundations created during for-profit conversions of nonprofit health care organizations contribute some of the CHIs' financing. Other large foundations contribute to these initiatives through evaluation, policy analysis, and premium support.

Table 2 shows the two CHIs' sources of financing for 2004. The funding was quite diverse, for both premiums and outreach costs. Santa Clara County had to raise more money, more than $16 million in 2004, and San Mateo raised slightly above $7 million. Stakeholders also contributed a significant, in-kind amount.

Most of the funding was for the Healthy Kids premiums, which accounted for about 75 percent of the total CHI expenditures. The premium paid to the health plan was a little more than $1,000 per child per year, which was $12.3 million in Santa Clara, covering an average of about 12,300 children under Healthy Kids, and $5.6 million in San Mateo, covering an average of about 5,600 children.

In addition to securing a large, diverse funding base, other local jurisdictions must remember that not all the money to be raised is for premiums. Nonpremium financing, mainly to cover the outreach/enrollment

TABLE 2
Financing for the Children's Health Initiatives, 2004

	Santa Clara County		San Mateo County	
Source by Type of Expense	$ (1000s)	%	$ (1000s)	%
Healthy Kids premiums				
County government	3,000	18.4	1,706	23.8
City government	1,800	11.0	—	—
First 5 commission[a]	2,959	18.2	945	13.2
Hospital districts[b]	—	—	1,932	26.9
California HealthCare Foundation	594	3.6	500	7.0
California Endowment	130	0.8	50	0.7
David and Lucile Packard Foundation	1,545	9.5	—	—
Health Trust	594	3.6	—	—
Peninsula Community Foundation	—	—	250	3.5
Santa Clara Family Health Plan Foundation	1,190	7.3	—	—
Other foundations	209	1.3	200	2.8
Individuals/corporations	281	1.7	—	—
Subtotal	$12,302	75.4%	$5,583	77.8%
Outreach				
County government	1,190	7.3	—	—
City government	300	1.8	—	—
First 5 commission	—	—	206	2.8
David and Lucile Packard Foundation	—	—	545	7.6
Santa Clara Family Health Plan Foundation	605	3.7	—	—
Other foundations	350	2.2	383	5.3
Medi-Cal administrative activities	700	4.3	128	1.8
Federal "earmark"[c]	350	2.2	—	—
Subtotal	$3,495	21.5%	$1,262	17.6%
Administration	$500	3.1%	$330	4.6%
Grand Total	$16,297	100.0%	$7,175	100.0%

Notes: Some data are for fiscal years; some are for calendar years; and some data are estimated. San Mateo County also contributed $1 million to a reserve fund not included in the table.
[a]First 5 commissions distribute state tobacco tax revenue for programs for children ages 0 to 5.
[b]Hospital districts have a special taxing authority to support health services.
[c]Authorized in special legislation by the U.S. Congress.

activities described later, is about $4 million a year in Santa Clara and $1.5 million in San Mateo County. The county governments contribute much of the money directly, although other sources pay for most of the premium financing. Both counties can take money from the commissions that administer tobacco tax money, which is used to cover all premiums for children aged zero to five. In San Mateo County, another source of quasi-governmental funds is two local hospital districts with special taxing authority. When adding these two sources to the direct governmental financing, just under half of Santa Clara County's funding is from taxpayers, and about two-thirds of San Mateo County's is from taxpayers. The remainder comes from private sources, principally foundations.

The mix of funding sources is equally varied for outreach funding. For outreach, however, the federal government contributes money in two ways. Medi-Cal Administrative Activities (MAA) federal match is available for some public agency outreach. In addition, a local member of the U.S. House of Representatives ensured that Santa Clara County would receive special federal outreach funding, called "the Earmark," each year beginning in 2002. Notably absent in 2004 was any state government financing. The $50 per application fee that the state paid to application assistors for Healthy Families applications was dropped in 2003 and then reinstituted in 2005.

Activities of the CHIs

The Healthy Kids Program

In order to cover all children in the counties, a way had to be established to cover those children who were not eligible for either of the existing public programs, that is, children with undocumented immigration status and those whose family income exceeded the level for public coverage. Both counties accordingly developed a new insurance product called "Healthy Kids."

To do this quickly, both counties based their Healthy Kids managed care programs on precursor programs. To a large extent they adopted the Healthy Families (SCHIP) benefit package, with limited cost sharing from families, and they administered the programs through the existing public health plans. Table 3 contrasts the two Healthy Kids programs with Healthy Families.

TABLE 3
Key Features of Healthy Kids and Healthy Families Programs, Santa Clara and San Mateo Counties, 2004

	Healthy Kids Santa Clara County	Healthy Kids San Mateo County	Healthy Families
Health plan	Santa Clara Family Health Plan	Health Plan of San Mateo	Various plans
Age group	0–18	0–18	0–18
Income group	0–300% of FPL[a]	0–400% of FPL	0–250% of FPL
Waiting period (time without private insurance)	3 months	6 months	3 months
Benefit limits			
Inpatient	None	None	None
Other outpatient	None	None	None
Dental	2 cleanings/year	2 cleanings/year	2 cleanings/year
Vision	None	$75 limit on frames / $110 limit on elective contact lenses	None
Outpatient mental health	20 visits/year	20 visits/year	20 visits/year
Prescription drugs	None	None	None
Copayments			
Inpatient	None	None	None
Preventive services	None	None	None
Other outpatient	$5	None	$5

(*Continued*)

TABLE 3—*Continued*

	Healthy Kids Santa Clara County	Healthy Kids San Mateo County	Healthy Families
Dental	None	None	None
Vision	$5	$5	$5
Outpatient mental health	$5	$5	$5
Prescription drugs	$5	$5	$5
		$250 copay limit/family/year	$250 copay limit/family/year
Family premiums[b]			
0–150% of FPL	$4/child/month ($12 maximum/family)	$4/child/month	$4/child/month ($12 maximum/family)
151–250% of FPL	$6/child/month ($18 maximum/family)	$6/child/month	$6/child/month ($18 maximum/family)
251–300% of FPL	$6/child/month ($18 maximum/family)	$12/child/month	Not applicable
301–400% of FPL	Not applicable	$20/child/month	Not applicable
Remaining premium (excluding family contribution)	$87/member/month	$89/member/month	Not available

Notes: [a]FPL means "federal poverty level."
[b]In Santa Clara County, parents may choose to pay premiums each month, pay three months in advance and get the fourth month free, or pay nine months in advance and get the last three months free. In San Mateo County, parents are billed for premiums on a quarterly basis but may pay the first three quarters in advance and receive the fourth quarter free. The premiums for Healthy Families come from the public plans. Premiums for private plans are slightly higher.

Both counties' Healthy Kids programs cover all children aged zero to eighteen. One of the biggest differences in the programs is the amount of family income under which the children may qualify. For Santa Clara County, the upper limit is 300 percent of the federal poverty level, and for San Mateo County, it is 400 percent, due to the high cost of living in the county. The upper limit for Healthy Families is only 250 percent of poverty.

Because of concerns that families might voluntarily give up their private insurance in order to qualify for public coverage, San Mateo County limits its coverage to children who have not had private insurance for at least six months. In Santa Clara County, following the Healthy Families policies, the waiting period is three months.

The two counties' Healthy Kids benefit packages are similar and also are similar to Healthy Families, with more generous coverage compared with that of private insurance. Most important, the plans cover dental, vision, and mental health services, although with some limits. But they have no limits on inpatient stays, outpatient services, or prescription drugs.

The plan's premium per enrolled child per month is about $90 in the two counties and has two components: the amount from the premium subsidies, by far the larger component, and the amount provided by the families. The sum of the two amounts is about the same as the monthly statewide Medi-Cal capitation rate (Fox et al. 2005), although the Medi-Cal premium excludes dental costs, which are contracted separately.

When the program began, how much the Healthy Kids program would cost was not clear. Consequently, premiums were set to correspond to those for Healthy Families. Indeed, when Healthy Families was implemented statewide earlier, bids were requested from insurance plans, which often based them on their experience with the Medi-Cal population. At that time policymakers did not know that Medi-Cal children would have higher use rates than Healthy Families and, later, Healthy Kids children.

In addition, the monthly premium for Healthy Kids does not vary according to the age of the child or other factors. The small portion paid by the families ranges from $4 per child per month for low-income families below 150 percent of poverty—the majority of families—to higher amounts for higher-income families. The two counties differ on the premiums for higher-income families, with San Mateo charging somewhat

more. In neither county do the premiums impose a large financial burden on families. Both counties also have funds to cover the family's premiums in hardship cases.

An important feature of both initiatives is their use of the local publicly sponsored Medi-Cal managed care plan as the sole health plan for Healthy Kids. The dominant providers in the network for both plans are the county-operated hospitals and clinics, as well as some nonprofit clinics. Most of the counties' private providers, especially specialists, do not participate actively. Indeed, most have little economic motivation to participate, and our interviews with nonparticipating providers revealed that most were not familiar with the new program. San Mateo County particularly has tried to involve private providers, but with little success.

Table 4 lists some of the prominent characteristics of the Healthy Kids population. By December 2004 Santa Clara Healthy Kids had 12,689 enrollees, and San Mateo Healthy Kids had 5,156. In addition, Santa

TABLE 4
Key Characteristics of Enrollees in Healthy Kids, 2004

	Santa Clara County	San Mateo County
Size of enrollment (December 2004)	12,689	5,156
Size of waiting list (December 2004)	1,546 (6–18 year olds only)	None
Age		
0–5	16.6%	22.2%
6–12	47.6	33.2
13–18	35.7	44.6
Family income		
0–150% of FPL[a]	74.0%	78.1%
151–250% of FPL	20.7	12.9
251–300% of FPL	5.2	4.8
301–400% of FPL	n.a.	4.3
Percent speaking Spanish at home	83.7	86.2

Notes: For Santa Clara County, demographic data (age, family income, and percent speaking Spanish) are for all children enrolled in July 2003 who remained enrolled for the following year. For San Mateo County, demograhic data are for children who enrolled at any time between July 2003 and June 2004 who remained enrolled for a full year.
[a]FPL means "federal poverty level."

Clara County had a waiting list of 1,546 children at that time, since the county was forced to cap enrollment for children ages six to eighteen because of a lack of premium financing.

Based on the Medi-Cal experience, both counties overestimated the proportion of children aged zero to five. This overestimate has had important financial repercussions for the CHIs, since the tobacco tax commissions can provide premium support for only the youngest age group. Indeed, the counties have not been able to spend all the dollars they set aside for premiums for the youngest children, while at the same time Santa Clara has a waiting list for children aged six to eighteen. In retrospect it is logical that the Healthy Kids enrollees would be older, since the youngest children are more likely to have been born in the United States and therefore would be citizens and eligible for the other public programs.

Table 4 also shows that even though both programs' income limits are higher than those for most public insurance programs for children around the country, few children in the income categories above 250 percent of poverty have enrolled (less than 10 percent of total enrollees in either county). The reason for this is not clear but may pertain to the continued stigma of a public insurance program or the fact that fewer children in the higher-income groups are uninsured than anticipated. Consequently, the large majority of enrollees are undocumented immigrant children.

Outreach and Enrollment

County partners were aware that merely establishing an insurance program to cover those without other forms of insurance would not achieve their goal of universal coverage.[4] Since the families of uninsured children—particularly undocumented children—are difficult to identify and contact, the counties created special outreach and enrollment programs to reach them. Next to establishing the Healthy Kids program, coordinated outreach and enrollment assistance are the most important activities supported directly by the CHIs, and these activities are very resource intensive.

In both counties, outreach and enrollment efforts involve multiple partners. The activities are coordinated by an outreach committee, staffed by the health department, but with heavy involvement from social service agencies that reach families applying for other forms of help. Both

counties also have involved local community-based organizations and schools that serve families in other capacities. Santa Clara County's, but not San Mateo County's, health plan also is very active.

Outreach is combined with an effort to enroll children right away or to make an appointment elsewhere with someone who will help them. The enrollment assistor is responsible for informing parents that coverage is available and for finding the right program in which to enroll the child. County partners consider this assistance to be essential in order to enable parents to complete an application successfully.

The CHIs sponsor or participate in many community events in order to advertise the availability of health insurance and application assistance. While the frequency of such events has declined as the initiatives have matured, Santa Clara County held almost 200 events in 2003 alone, the third year of its initiative, and the smaller San Mateo County held 134 in the same year, its first CHI year. Neither CHI relies heavily on paid media advertising, finding that personal word of mouth is more effective. Personal outreach is particularly useful for relieving parents' concerns that enrolling their child might constitute a "public charge" and thereby jeopardize their ability to obtain legal status. The counties view the linkage between outreach and enrollment as essential, and both use a "one-on-one" model of application assistance in which a trained application assistor helps a parent complete the application for health insurance. Santa Clara County has thirty-four sites, and the smaller San Mateo County has forty sites, where an outreach/enrollment worker often works at several sites. The sites are clustered in those areas of the counties where most of the low-income children live. If Medi-Cal applications completed at social services agencies are included, about three-fourths of applications for the three public programs are filled out at social services agency sites. A better measure of CHI-sponsored activity, however, excludes the Medi-Cal applications completed at social services sites, since those activities usually predated the CHIs. Using this approach, a majority of applications are filled out in clinics (70.8 percent in Santa Clara and 64.9 percent in San Mateo).

Both counties' CHIs employ a large number of application assistors, 32.5 full-time equivalents in Santa Clara County and 24 in San Mateo. These workers are encouraged to help families apply for any children's insurance program. The many staff and the large number of sites underscore the labor intensity of enrolling children using the one-on-one model of application.

Even though San Mateo County has only one-third as many poor children as Santa Clara County does (see table 1), it allocates more resources per child to enrollment assistance, because of San Mateo's greater emphasis on school-based outreach, which uses more sites. School-based outreach is very time-consuming, because it requires the support and permission of school personnel to distribute information to children and parents. For example, in 2004 in San Mateo County, fourteen of the twenty-three school districts sent out a "Request for Information" (RFI) to parents in order to identify uninsured children; eleven districts held CHI-sponsored presentations or enrollment events; and ten districts had enrollment assistors present at some schools on a regular schedule. Two especially labor-intensive school-based programs, one in each county, use a full-time application assistor to obtain school lunch applications that screen for Medi-Cal eligibility and contact the parents of uninsured children who appear to be eligible for public insurance.

The productivity per worker in terms of applications completed is difficult to compute because of the lack of uniform data. Using data from monthly manual tallies reported by application assistors, the number of applications per full-time worker was just under fifty per month in Santa Clara County and just under thirty per month in San Mateo County. This relatively low productivity (about one to three applications each day, including renewals) is due to several factors. Productivity varies greatly across sites, with the highest productivity in very high-volume clinics in both counties. Santa Clara's higher productivity is due partly to its greater focus on clinics.

While clinic-based enrollment is more productive in terms of applications per worker, school-based outreach/enrollment plays a special role, since it reaches children who are not yet in contact with the health system. In addition, while productivity in the school-based sites is generally lower, one San Mateo County school outreach/enrollment worker who did intensive enrollment follow-up generated about the same number of Medi-Cal applications on average (thirty per month) as did other outreach/enrollment workers in the county, demonstrating that school-based enrollment can be effective when planned and managed well.

A major concern is the fragmentation introduced by an additional insurance program (Healthy Kids) to an already fragmented application system for low-income families. In order to both increase the productivity of enrollment assistors and reduce this fragmentation, in 2004 both counties began using the "One-e-App." An enrollment assistor

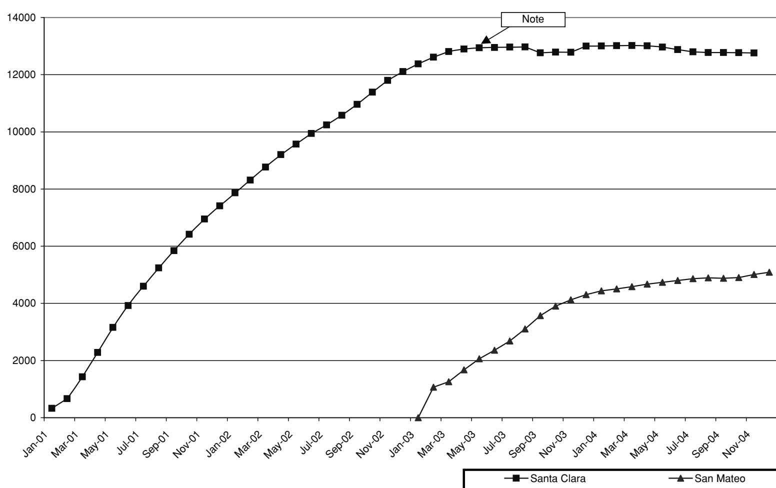
enters the information on the application into this web-based system, which then searches for the appropriate program. The application is then automatically forwarded to the appropriate program without duplicate paperwork. Although One-e-App can be modified to include other programs (such as food stamps), these features have not yet been incorporated into either county's application process.

Outcomes of the CHIs

While the preceding description shows that a county-based children's health insurance program can be developed rapidly when it is based on an existing infrastructure, this does not mean that it is worth the large expense unless it enrolls new children and gives them needed health services. To explore the CHIs' outcomes, we examined trends in the number of children enrolled in public coverage in the counties, the enrolled children's use of services, and the effects of the CHIs on the counties' health systems.

Enrollment Growth

The primary purpose of the CHIs is to enroll uninsured children in public health insurance. Figure 1 shows the growth in enrollment in the Healthy Kids program, beginning with its implementation in Santa Clara County in January 2001 and in San Mateo County in February 2003. The growth was very rapid in the first two years in Santa Clara and in the first year in San Mateo but then leveled off, for different reasons in each county. In May 2003, Santa Clara's Healthy Kids enrollment was capped because the number of children in the program aged six to eighteen (for whom the funds were the most limited) exceeded initial expectations. San Mateo's Healthy Kids enrollment leveled off sooner, in the second year, when it was just approaching the number of children for which the county had budgeted funds. Although the county partners there expected to impose a cap on enrollment sometime in the second or third year, they had not yet needed to do so at the time of this writing, because attrition from the program had been approximately the same as new enrollment. It is possible that Santa Clara County underestimated the number of uninsured undocumented children aged six to eighteen and that San Mateo's estimates were about right. Or more eligible children may have



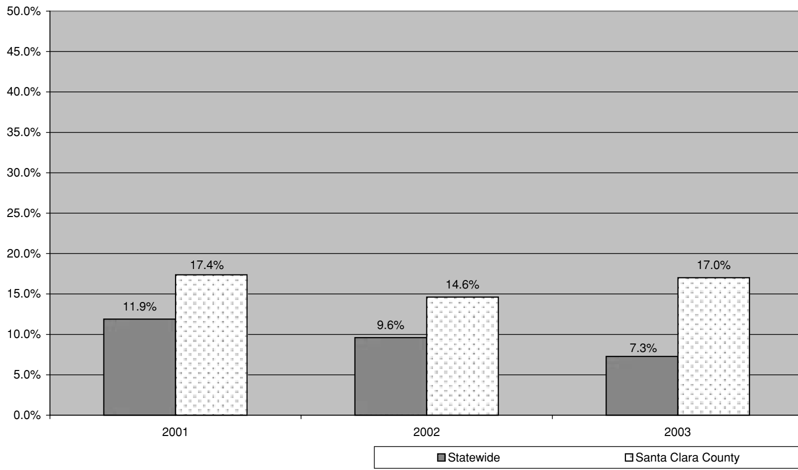
Note: Cap established for Santa Clara Healthy Kids program in May 2003.

FIGURE 1. Santa Clara and San Mateo Counties Healthy Kids Program Enrollment

enrolled in Santa Clara than in San Mateo. Unfortunately, we do not have enough information to accurately estimate the degree of penetration in either county.

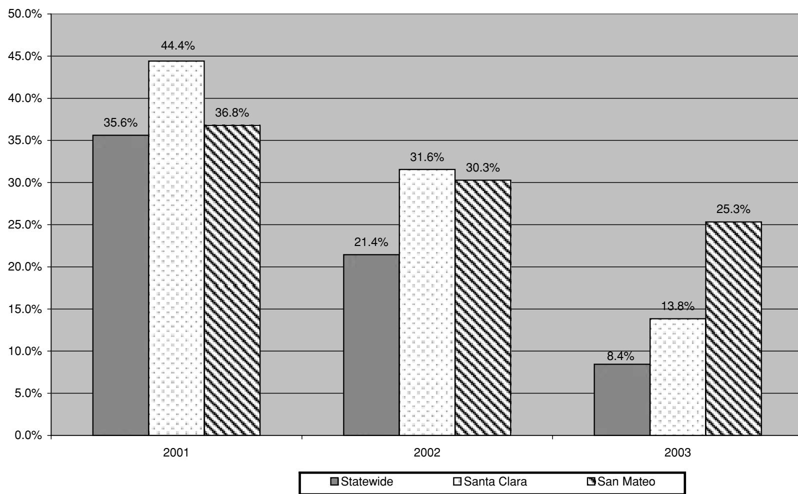
Since a major goal for both counties is to enroll all eligible children in Medi-Cal and Healthy Families (and thus use federal and state funds to finance their coverage), it is equally important to track the growth of these two public programs. Figures 2 and 3 show trends in growth rates and compare the growth of the county and the state programs.

As the state's largest public program, Medi-Cal dominates program enrollment in both counties, but unfortunately we lack complete information about the growth of Medi-Cal for children for the time period we are studying. Statewide data are available for 2001 to 2003 from the Urban Institute's tabulations from a national Medicaid enrollment data base and from the counties themselves for certain years. Figure 2 shows the growth of Santa Clara's program compared with that statewide for 2001 to 2003 (the first three years of that CHI). The growth in Medi-Cal for children in Santa Clara County was about three times as great as the statewide growth in 2001 and was substantially greater in 2002/2003. A study by Trenholm (2005) offers additional evidence of the CHI's effect on Medi-Cal growth, showing that in the first two years of



Notes: Statewide rates are calculated by fiscal year (i.e., October 2000–September 2001); Santa Clara County rates are calculated by calendar year (i.e., January 2001–December 2001).

FIGURE 2. Growth in Medi-Cal for Children Enrollment 2001–2003



Note: Rates calculated by calendar year (i.e., January 2001–December 2001).

FIGURE 3. Growth in Healthy Families Enrollment 2001–2003

the Santa Clara County CHI, Medi-Cal for children grew significantly faster than it did in matched comparison areas in the state with no CHI-type activity.

In contrast, in San Mateo County in 2003 (the first year of the program when outreach was most intensive) there was essentially no change in Medi-Cal enrollment for children (data not shown). This is puzzling, since both counties were still experiencing economic difficulties in 2003. For example, the enrollment for food stamps rose substantially in both counties in 2003, a reflection of the economic hardship.

Both counties' enrollment in Healthy Families climbed steadily throughout this implementation period, at a higher rate than did the state's enrollment (figure 3). For example, in 2001—the first year of the Santa Clara program—enrollment in Healthy Families grew rapidly, about 45 percent, in contrast to about 35 percent in both San Mateo County and statewide. Because this was right after the state's Healthy Families program was introduced, when California was spending money on outreach around the state, a better comparison may be 2002 or 2003 when the state-funded outreach diminished. For example, in 2003 the enrollment in Healthy Families was much higher in Santa Clara County (13.8 percent) and especially San Mateo County (25.3 percent)—the first year of that county's implementation—than it was statewide (8.4 percent). From this limited information, Santa Clara County's CHI seems to have had a positive effect on Medi-Cal enrollment and, to a lesser extent, on Healthy Families enrollment, whereas San Mateo County's CHI helped only to increase the Healthy Families enrollment.

The reason for the differences in two counties' growth of enrollment in Medi-Cal is not clear. Measures of outreach intensity—such as a ratio of the number of outreach events, sites, or enrollment assistors for poor children—suggest equally intensive outreach. The difference could be the responsibilities of two public health plans, in which most Medi-Cal children are enrolled. In Santa Clara County, the plan (through its marketing department) takes an active role in retention, whereas the plan in San Mateo does not. In addition, the differential Medi-Cal enrollment could be due to the two counties' differences in the incomes of families of documented children (i.e., those eligible for Medi-Cal or Healthy Families). Because Santa Clara County has a higher poverty rate (see table 1), it should also have more documented low-income children who are eligible for Medi-Cal than San Mateo County does.

A more revealing statistic is the change in the percentage of uninsured children in both counties. Again, little information is available. We have data from the California Health Interview Survey—a population-based survey—but county-level estimates are not reliable because of their small sample sizes. When both counties are combined, the rate of uninsured children below 300 percent of poverty did not change between 2001 and 2003 (more recent data are not available), remaining at about 12 percent. These data suggest a decline in Santa Clara County only (where the CHI had been in effect for about two years at the time of the 2003 survey), but the rates are not reliable enough to be published (see "Ask CHIS" at http://www.chis.ucla.edu; accessed July 17, 2006).

Although we cannot draw any firm conclusions, the counties still seem to be struggling to achieve their goal of universal insurance for low-income children. If so, this is likely due to many factors, one being program churning, that is, when children enrolled in insurance do not renew their coverage. Unfortunately, retention is difficult to measure, and good statistics that are comparable across counties and programs are not available. Both counties have relatively high rates of Healthy Kids retention (more than 80 percent of children renew each year), but retention in the other two public programs is lower. Hill and Lutsky (2003) estimated that in 2000 the Healthy Families retention statewide was about 75 percent, but another report using other methods suggested that in 2002 it was lower for both Medi-Cal (64 percent) and Healthy Families (60 percent) (Testa et al. 2003).

Utilization of Services

An important secondary goal of the CHI is providing needed health services for children. Table 5 shows some of the health services used by Medi-Cal, Healthy Families, and Healthy Kids enrollees in the two county-sponsored health plans, based on the health plans' encounter data. (Note that some Medi-Cal children in Santa Clara County are not enrolled in the plan and that in both counties, many Healthy Families children are enrolled in other plans.)

As table 5 shows, the reported use of preventive care is low, particularly for school-age children and adolescents. In both counties and for all three programs, only about one-third of school-age children and adolescents in the program made a visit for preventive care in the past year. Their use was higher, though, when considering the rate of any ambulatory

TABLE 5
Annual Utilization of Services under Medi-Cal, Healthy Families, and Healthy Kids Children Continuously Enrolled (2003–2004)

	Santa Clara Family Health Plan			Health Plan of San Mateo		
	Medi-Cal	Healthy Families	Healthy Kids	Medi-Cal	Healthy Families	Healthy Kids
Percent for						
Preventive visit						
0–5	77.0	73.8	71.1	60.5	63.3	50.0
6–12	33.5	35.9	31.9	26.7	34.5	30.2
13–18	29.8	32.6	25.7	21.7	33.8	26.8
Total	50.4	43.9	36.2	43.9	42.7	33.5
Any ambulatory visit						
0–5	89.3	92.1	90.8	84.5	89.2	82.4
6–12	67.2	73.7	70.7	60.6	69.3	66.5
13–18	61.9	68.1	60.8	59.8	68.0	64.0
Total	75.1	76.5	70.5	73.3	74.8	69.2
Hospital stay						
0–5	3.8	1.1	3.4	4.6	2.3	1.3
6–12	2.0	0.6	1.7	1.3	0.5	0.6
13–18	2.8	0.4	2.4	3.8	1.5	0.7
Total	2.9	0.7	2.2	3.5	1.3	0.8
Emergency room visit						
0–5	29.8	18.9	15.1	41.0	25.6	17.5
6–12	16.5	10.1	7.7	20.7	11.9	10.6
13–18	15.6	9.3	8.9	24.2	14.2	11.1
Total	21.7	12.0	9.3	32.1	16.3	12.3
Dental visit[a]						
0–5	—	—	50.6	—	—	49.1
6–12	—	—	78.3	—	—	61.7
13–18	—	—	56.8	—	—	51.6
Total	—	—	61.3	—	—	55.6
Vision visit[a]						
0–5	11.7	9.6	11.4	1.3	—	2.1
6–12	16.5	7.2	16.9	9.0	—	9.7
13–18	17.9	4.8	17.2	9.8	—	10.4
Total	14.9	7.1	16.1	5.0	—	8.2
Number of children						
0–5	14,331	1,739	1,572	11,103	648	1,011
6–12	12,994	3,701	4,517	6,137	1,121	2029
13–18	7,793	2,016	3,377	3,530	465	1509
Total	35,118	7,456	9,466	20,770	2,234	4,549

Notes: This table lists all children enrolled in public health plans in July 2003 for Santa Clara County and between February 2003 and January 2004 for San Mateo County. It includes all the children's services for one full year following the first month of their enrollment in the plan. For example, for enrollees in July 2003, it includes services for July 2003 through June 2004.

While all providers are required to submit encounter records, preventive and ambulatory services for all three programs in Santa Clara and for Medi-Cal in San Mateo County may be underreported, since some primary care providers are capitated.

[a]Dental care is capitated for Medi-Cal and Healthy Families enrollees, and vision care is capitated for Healthy Families enrollees. No encounter records are available.

visit, and presumably some preventive care was provided during "sick visits." In all three programs, about two-thirds of school-age children and adolescents made such visits, especially children aged one to five (more than 80 percent). The Healthy Families program in both counties had the highest number of visits, with somewhat more in Santa Clara County than in San Mateo County. In 2001 the rates of use of ambulatory care by poor Latino children across the nation were similar to those reported here for Healthy Families. However, the rates were much lower than those for all children nationally (National Center for Health Statistics 2004).

The differences among the three programs were greater for emergency room visits and hospital stays, whose numbers were higher for Medi-Cal than for Healthy Families and Healthy Kids. Healthy Kids had the lowest utilization of these two expensive services in San Mateo County, and Healthy Families children had the lowest rates in Santa Clara County. Information about dental care use was available only for the Healthy Kids children: about 50 to 60 percent of children visited a dentist annually depending on age. In addition, about 15 percent of both Medi-Cal and Healthy Kids school-age children and adolescents in Santa Clara County and 10 percent in San Mateo County made a vision care visit.

One possible reason that these rates appear low is the underreporting to the health plans of medical, dental, and vision "encounters." Some primary care providers receive capitated reimbursement from the health plans. Although these providers are required to report "encounter" records, they may underreport them, since their payments do not depend on them. The Health Plan Employer Data and Information Set (HEDIS) is collected by many health plans for quality assurance. It contains information from claims/encounter records in addition to information from medical records. (More information on HEDIS is available at www.ncqa.org/programs/hedis; accessed July 17, 2006).

Table 6 shows data the Santa Clara Family Health Plan prepared for HEDIS reports of all three programs in 2004 and for Medi-Cal and Healthy Families from the Health Plan of San Mateo for 2002 and 2004. Also shown are national data for all health plans whose enrollment is dominated by Medicaid enrollees, as well as statewide data for Healthy Families enrollees in 2002. Although the performance of the Santa Clara and San Mateo plans was generally better than state and national norms for similar plans, the consistency of HEDIS use rates across all three programs and across varying data sources suggests the difficulty for public insurance programs in ensuring preventive care for enrolled children.

TABLE 6
Health Plan Employer Data and Information Set (HEDIS)
Utilization Measures, 2002–2004

	Percent of Children Receiving Recommended Care		
	Childhood Immunizations (%)	Well Child Visits (ages 3–6) (%)	Adolescent Well Visits (%)
Santa Clara Family Health Plan 2004			
Medi-Cal	66	72	34
Healthy Families	76	70	36
Healthy Kids	75	66	30
San Mateo Family Health Plan 2002			
Medi-Cal	57	56	28
Healthy Families	—	69	35
San Mateo Family Health Plan 2004			
Medi-Cal	62	55	30
Healthy Families	—	73	44
California Statewide Healthy Families 2002			
	72	63	34
National HEDIS Data for Medicaid Plans			
	62 (2003)	58 (2002)	37 (2002)

Sources: (1) Santa Clara data: Santa Clara Family Health Plan; (2) San Mateo data: Health Plan of San Mateo; (3) California statewide data: Healthy Families Program; (4) national data: childhood immunizations—National Committee for Quality Assurance, 2004; well child and adolescent visits—American Public Human Services Association, 2003.

Depending on the program, year, and plan, only 57 to 76 percent of children had up-to-date immunizations; from 55 to 73 percent made all the recommended well child visits; and only 28 to 44 percent of adolescents made an annual well visit. Also while these rates seem low, they are a dramatic improvement over the preventive care the children received when not insured in Santa Clara County (Trenholm et al. 2005). Still, the low rates show that this is an area where the CHIs might place a greater emphasis.

Impact on Hospitals

The hospital systems, especially the public systems, have been very supportive of the CHIs, and tables 7 and 8 provide evidence that the CHIs may have had some limited positive financial impact on them. Table 7

TABLE 7
Hospital Discharges by Age and Payer, FY 2000–2003

	Children Aged 1–17	
	No Insurance	Public Insurance
Lucile Packard Children's Hospital		
2000	58	967
2001	48	1101
2002	6	1171
2003	14	1213
Percent change, 2000–2003	−75.9%	25.4%
Santa Clara County		
2000	286	2471
2001	223	2426
2002	65	2669
2003	96	2981
Percent change, 2000–2003	−66.4%	20.6
San Mateo County		
2000	36	213
2001	22	171
2002	13	157
2003	21	190
Percent change, 2000–2003	−41.7%	−10.8%
Total number of discharges		
2000	380	3651
2001	293	3698
2002	84	3997
2003	131	4384
Percent change, 2000–2003	−65.5%	20.1%

Note: Hospitals included in each county are as follows—Santa Clara County: Community Hospital of Los Gatos, El Camino Hospital, Good Samaritan Hospital, O'Connor Hospital, Regional Medical Center of San Jose, St. Louise Regional Hospital, San Jose Medical Center, Stanford Hospital, VA Palo Alto Health Care System, Kaiser Foundation Hospital–Santa Teresa, and Santa Clara Valley Health & Hospital System; San Mateo County: Mills-Peninsula Health Services, San Mateo Medical Center, Sequoia Hospital, Seton Medical Center, Kaiser Foundation Hospital–Redwood City, and Kaiser Foundation Hospital–South San Francisco (data for the Kaiser hospitals in San Mateo were unavailable for 2002).
Data Source: California Office of Statewide Health Planning and Development.

shows hospital discharges for children classified as "No Insurance" (including "self-pay" and "bad debt") or "Public Insurance" (including all public programs) from 2000 to 2003. Lucile Packard Children's Hospital is shown separately because it is on the border of the two counties and

TABLE 8
Outpatient Visits by Age and Payer, FY 2002–2004 Lucile Packard Children's Hospital (Santa Clara County) and San Mateo County Hospitals

	No Insurance	Public Insurance
Ages 0–5		
2002	3,256	27,211
2003	2,975	29,896
2004	2,367	34,867
% change	−27.3%	28.1%
Ages 6–18		
2002	5,093	19,684
2003	6,394	22,164
2004	4,049	28,811
% change	−20.5%	46.4%
Total		
2002	8,349	46,895
2003	9,369	52,060
2004	6,416	63,678
% change	−23.2%	35.8%

Note: San Mateo County hospitals include San Mateo Medical Center, Mills-Peninsula Hospital, Sequoia Hospital, and Seton Medical Center.

serves many of the children in both. As shown, the number of discharges of uninsured children fell by 65.5 percent over the period (with a slight increase in 2003 from 2002), while the discharges of Medi-Cal children rose by 20.1 percent. Still, some children remain uninsured, indicating that the CHI outreach may not be finding and enrolling all eligible low-income children.

The positive trends apply to outpatient care as well. Table 8 lists the data for only one Santa Clara County hospital, Lucile Packard Children's Hospital, and for four San Mateo County hospitals. The number of outpatient visits by uninsured/self-pay children dropped by 23.2 percent from 2002 to 2004, and visits by publicly insured children climbed by 35.8 percent.

Impact on Public Health Systems and Health Plans

The public health systems and health plans in both counties have benefited from these programs, suggesting that the systems may be better

able financially to either improve services for children or increase access for uninsured adults. Since both counties have public hospital systems that provide inpatient and outpatient care, the decline in uninsured stays and visits just described has resulted in less uncompensated care for children in those facilities. At the same time, some of the cost "savings" are actually a shift of the cost from directly subsidized care by the county into a county-funded subsidy for the insurance program.

The county-sponsored plans have benefited financially as well, because the cost of care for Healthy Kids is less than the premiums. Table 5 shows that the rates for the most expensive services are generally lower for Healthy Kids than for other public programs. In San Mateo County, the costs to the plan for services under Healthy Kids and Healthy Families are similar, and both are about half the cost for Medi-Cal children. The reason is that Medi-Cal includes some very expensive care, such as maternity care for teen mothers, which is generally not provided by the other two programs.

This "subsidy" that the plans receive is being used in different ways in the two counties. In the plan's first year, the Health Plan of San Mateo kept about $1 million in excess revenue to offset losses in its Medi-Cal business, particularly those for the SSI (supplemental security income) population for which Medi-Cal capitation rates have not kept pace with costs. After the first year, the plan is paying back funders according to their contribution to the premiums. Santa Clara County's plan contributes excess revenue to the Santa Clara County Family Health Plan Foundation, which in turn funds the CHI (contributing $1.8 million in 2004; see table 2).

Conclusions

This article described how two California counties tackled a difficult local problem, the continued presence of uninsured children despite the expansion of public coverage. Santa Clara County's and San Mateo County's Children's Health Initiatives, two of the first in California, addressed several of the difficulties of expanding health insurance coverage for children by building a local coalition and raising a large amount of public and private funds locally.

This review of the early implementation of these two CHIs provides some optimism that—even during difficult economic times—with strong leadership and creative financing, local communities can reduce

the number of uninsured children. The CHI experience illustrates the importance of the collaboration of several agencies, particularly health and social service agencies. Outreach in clinic settings appears to be a cost-effective model for these counties, and well-structured school outreach can be effective, too.

Revisiting the questions that we posed early in the article, we offer the following answers:

- *What are the principal components of the Children's Health Initiatives?* (1) Strong leadership, especially within key public agencies; (2) the collaboration of multiple public and private organizations; (3) adequate sources of local public and private funding; (4) a preexisting infrastructure on which to build a new health insurance program, including a managed care plan willing to enroll children; and (5) a labor-intensive model of outreach and enrollment. More research is needed on the most cost-effective outreach/enrollment activities in order to develop models that are feasible for the average community.
- *How much does this program cost, and who funds it?* The cost of care was relatively inexpensive in the early years ($1,000 or less per year per child). In order to find and enroll all children, outreach and enrollment must be very resource intensive. A mix of public and private financing is necessary, but finding and sustaining adequate funding is extremely difficult.
- *Does this program expand health insurance coverage and increase use of health services?* The new Healthy Kids programs enrolled children rapidly, and the programs also appear to have increased enrollment in Healthy Families. The impact on Medi-Cal enrollment differed by county for reasons that are not clear. The fragmentation in coverage programs in California makes the continuity of enrollment particularly difficult. Merely providing health insurance does not ensure that children will actually use the preventive care services. Indeed, the use of preventive services was lower than the CHI goals for all three public programs.
- *Does the program lead to financial improvements for county health systems?* The county hospitals and the public managed care plans have had moderate financial benefits.

Despite the difficulties, California has a strong interest in using the CHI model to expand health insurance coverage to include all children.

A statewide California poll in February 2005 found that 78 percent of voters supported a plan to cover all children (including undocumented children), with two-thirds of Republicans supporting the plan (Fairbank, Maslin, Maullin & Associates 2005). Even though the governor vetoed legislation in October 2005 to cover all children, he has indicated that he is open to considering supporting such a plan should the state's financial circumstances improve.

This interest is not confined to California. Many states have special programs to help immigrant families enroll their children in existing health insurance programs (Morse 2000). Twenty states and the District of Columbia provide some state-funded health insurance to noncitizen children, although it usually is for documented children. Only four states (Washington, D.C., Massachusetts, New York, and Rhode Island) provide full coverage to undocumented children (Alker 2005; Fremstad and Cox 2004). In addition to California, eight states—Hawaii, Illinois, Massachusetts, Oregon, Pennsylvania, Tennessee, Wisconsin, and Washington—have greatly expanded their coverage for children, which is in various stages of development, with implementation in Illinois scheduled for July 2006. At the national level, there is a bipartisan proposal to launch a large outreach effort to identify and enroll all eligible children. But before a major investment is made, it seems important to consider the lessons from these smaller experiments in California in order to use the outreach funds most effectively.

The generally positive lessons from these two counties' experience should be balanced by determining whether a CHI model is suitable for other places around the country. Political opposition to a program that covers undocumented children may make such a program impossible in other parts of the country. County-based rather than, for example, statewide initiatives may be more likely to overcome such opposition, since people see the children in their own communities and are more aware of their problems as "neighbors."

Most important, not all communities have the same financial resources of Santa Clara and San Mateo counties, including a special tobacco tax, other special taxing authority (as in San Mateo's hospital districts), and wealthy foundations willing to contribute to the effort. Raising enough money to cover all children will be very difficult in other places, especially those with large numbers of undocumented children who cannot be enrolled in existing public programs. Even relatively wealthy counties

have both limited financial resources and a limited ability to cover all such children. The greatest unsolved challenge for the CHIs is finding the financing to sustain their initiatives. Consequently, both are actively looking for ways to increase state and federal involvement.

The California legislature approved in 2005—which the governor vetoed owing to cost—a measure to expand the Healthy Families program with state funds to include all children in the state with incomes below 300 percent of the federal poverty level. An initiative to do this will now appear on California's November 2006 ballot. If passed, the Tobacco Tax Act of 2006 will increase the tax on cigarettes and other tobacco products by $2.60 per pack in order to fund the expanded insurance. The California model of using tobacco taxes for this purpose—with the rationale that it is beneficial for children's health and development—may hold promise in other places.

California may be a bellwether for the nation in addressing the problems of the uninsured and their access to health care: "California exerts an enormous influence on the magnitude of the nation's health access problem and is the key to success in dealing with that problem" (Leichter 2004, 178). Since about 15 percent of the nation's uninsured children in 2001/2002 lived in California (Robert Wood Johnson Foundation 2005), finding a solution in this state alone would go a long way to solving the nation's problem of uninsured children.

Endnotes

1. Other reports offer more detail on the development of each of these initiatives (Chimento, Jee, and Shukla 2004; Howell et al. 2004; Long 2001). More detailed studies of the impact of these programs on access, use of services, and health status are also under way, with findings in Santa Clara showing a strong positive impact (Trenholm et al. 2005).
2. The topics covered are background (the history of CHI development and policy environment); governance; financing; outreach, enrollment, and retention; population served by Healthy Kids; satisfaction with Healthy Kids and the CHI; and sustainability/replication. Detailed protocols for the site visit interviews are available from the authors.
3. In California, special public plans have been set up to operate managed care arrangements for Medi-Cal enrollees. Santa Clara County has a "two-plan model" in which the Santa Clara Family Health Plan functions as the public plan option (and others can choose to enroll in a private, designated plan). San Mateo County has a County Organized Health System, which has a single plan for Medi-Cal managed care. See www.chcf.org/documents/policy/MediCalFactsAndFigures.pdf; accessed July 20, 2006.
4. For more information on the two counties' outreach/enrollment systems, see Hughes 2006 for Santa Clara County and Howell et al. 2005 for San Mateo County.

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