County Efforts to Expand Health Coverage among the Uninsured in Six California Counties

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Executive Summary

For the past 20 years, counties in California have assumed primary responsibility for providing health care to uninsured individuals. In 1999, approximately 6.8 million Californians lacked health insurance coverage.[1] About 2 million of these uninsured individuals (30 percent) are potentially eligible to participate in existing publicly funded programs.[2] However, many adults (4.3 million) and children (350,000) do not meet the income, immigration, or categorical requirements of these programs and are likely to remain uninsured under current federal and state policies.[3]

To address gaps in public coverage at the state level, six California counties have expanded health insurance coverage or created access programs targeting two groups of uninsured individuals. This background paper summarizes major coverage expansions in these six counties (Alameda, Contra Costa, San Francisco, San Joaquin, Santa Clara, and Solano). Specifically, it identifies similarities and differences among the programs in terms of their target populations, benefits, outreach, enrollment, and retention strategies, and highlights some lessons learned for other counties and the state. Summary tables, which describe the major features of each program and their outreach, enrollment, access, and retention activities, are included at the end of the paper.

Although each county described in this paper has taken a different implementation path, all counties' expansion efforts have targeted either: (1) children who are not eligible for the Medi-Cal or Healthy Families programs or (2) low-income, uninsured adults. Each county has selected the Local Initiative or County Operated Health System (COHS) to administer the new program. Alameda, San Francisco, San Joaquin, and Santa Clara Counties supplemented existing funding streams with a combination of county general revenues, state funding, national tobacco settlement money, Proposition 10 funds, contributions from the Local Initiative, and grants from private foundations. In contrast, Contra Costa and Solano Counties reprogrammed existing state and county funds to improve the organization and delivery of health care services to uninsured adults.

The experiences of these six counties provide important lessons for policymakers in other counties and the state:

- In the absence of federal and state leadership, counties can take action to reduce the number of uninsured individuals.
- Sufficient administrative capacity and dedicated funding streams are necessary to develop and implement coverage expansions at the county level.
- In order to maximize their overall impact and limit substitution of one type of coverage for another, programs that expand coverage using local and private funds have put thorough screening mechanisms in place.
- Evidence from some counties suggests that the county programs have much higher application success rates than either Medi-Cal or Healthy Families.
- County-level solutions, however, are likely to be small in scale and short-term. Thus, state and federal funds would be needed to sustain and expand these efforts.

- Given the current bleak outlook for the state budget and the uncertainty surrounding the implementation of the Healthy Families waiver, however, the short-term sustainability of these programs is uncertain.
- These incremental efforts to expand coverage highlight the differential financial impact of direct funding of safety net providers versus the subsidization of health insurance.
- None of the county programs has involved private health plans in the development or implementation of these programs. This omission could have practical and political implications if it is expanded or replicated statewide.

Introduction

Health Insurance and Health Care for Low-Income Populations in California

California, with federal support in some cases, funds a number of programs to provide coverage for low-income individuals and those who are unable to obtain coverage in the private sector. As of January 2002, an estimated 6.1 million adults and children were enrolled in Medi-Cal.[4] As of October 2001, 475,000 low-income children had enrolled in Healthy Families. Access for Infants and Mothers (AIM) provides insurance coverage to 30,000 pregnant women and infants less than two years old.[5]

In 1999, 6.8 million Californians under 65 were uninsured.[6] According to recent estimates, nearly three-quarters (74 percent) of the uninsured populations (5.0 million) are adults and 1.8 million are children under 19.[7] More than two-thirds of these uninsured children are eligible for either Medi-Cal or Healthy Families. In spite of eligibility expansions, approximately 350,000 children statewide are unlikely to qualify for either program because of their immigration status or family incomes above the eligibility cutoffs. In contrast, only 14 percent of uninsured adults in the state are eligible for Medi-Cal coverage and none are currently eligible for Healthy Families.[8] Thus, 4.3 million uninsured adults are currently restricted from enrolling in public coverage.[9]

For the past 20 years, counties in California have assumed primary responsibility for providing health care to uninsured individuals. These services are financed using a mixture of federal, state, and local funds. Under the existing system, the state provides funding to counties, which are responsible for ensuring the delivery of public health services and indigent medical care services.[10] In return for state funds, counties agree to maintain specified levels of public health, inpatient, and outpatient expenditures. They also agree to use state funds to supplement and not supplant existing levels of health services. This relationship between the state and counties has been formalized through annual Standard Agreements that are administered by the Office of County Health Services within the Department of Health Services, and these funds are commonly referred to as realignment funds.

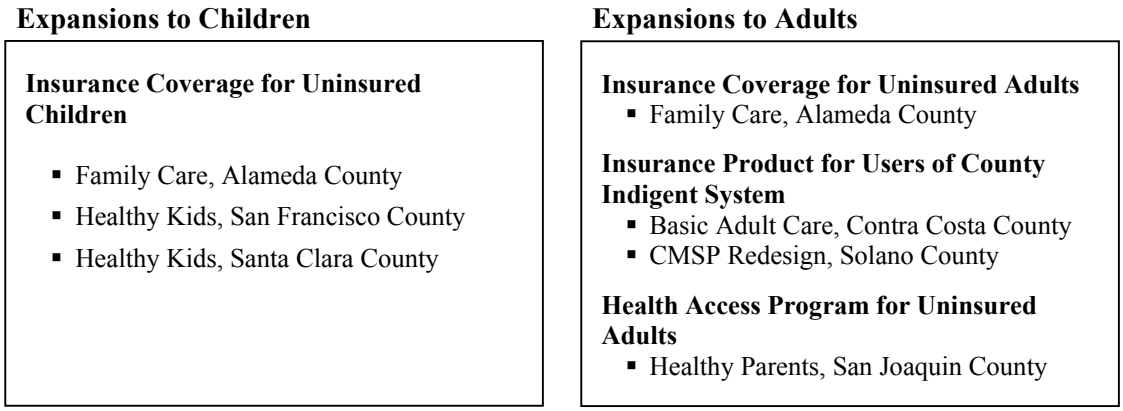
In order to understand the different choices that counties make in terms of providing and financing care for low-income uninsured individuals, it is important to consider the characteristics of the county's indigent health care system. California counties can be divided into three broad categories in terms of their financing and delivery of care to indigent populations: rural counties (Solano), urban counties that pay for indigent health services (San Diego), and urban counties that provide health services through publicly funded hospitals and

clinics (Alameda, Contra Costa, San Francisco, San Joaquin, and Santa Clara). Since the majority of the new funding from these new county programs will be paid to county hospitals and clinics, provider counties such as Alameda have clear financial incentives to expand coverage.[11] County Provider counties with a public health plan such as a County Operated Health System (COHS) or Local Initiative (LI) also possess significant administrative resources, which are essential to launching coverage expansions. Given these strong financial incentives to expand coverage, it is not surprising that five of the six counties described here are urban provider counties.

County Efforts to Expand Health Insurance Coverage

To date, six counties in the state have expanded or are in the process of expanding coverage to different groups of uninsured individuals (Figure 1). Three counties (Alameda, San Francisco, and Santa Clara) have expanded coverage among children who do not qualify for Medi-Cal or Healthy Families based on their immigration status or their family's income (Table 1). A second group of counties (Alameda, Contra Costa, San Joaquin, and Solano) has extended health coverage (or access) to uninsured adults. Solano and Contra Costa expanded insurance coverage to uninsured adults who currently participate in the county's indigent care programs in an effort to improve their access to care. Alameda has developed an insurance product that targets the uninsured parents of children with Medi-Cal or Healthy Families while San Joaquin has created an access program to improve health care use among the uninsured parents of children enrolled in Medi-Cal and Healthy Families.

Figure 1: Schematic Representation of Six California County Health Expansions



Methodology

The author contacted state and county officials, health advocates, and other researchers to identify counties that had embarked or planned to embark on health coverage expansions. This process generated a list of eleven counties throughout the state. Further research identified six that have implemented or were in the process of implementing coverage or access expansions. Between August and November 2001, the author conducted key informant interviews with county and health plan officials in these six counties to learn more about their programs. He also reviewed published and unpublished documents about the programs and analyzed relevant state health policies and legislation. Program officials reviewed an earlier draft of this document to

ensure that the descriptions of their program were accurate. Any remaining inaccuracies and all conclusions are the responsibility of the author.

Expanding Coverage for Children

Three counties have expanded coverage to uninsured children. Although the political dynamics involved in the creation of new health insurance products for low-income uninsured children vary by county, the target population, benefits, structure, and financing of Family Care in Alameda County, Healthy Kids in Santa Clara County, and Healthy Kids in San Francisco County are remarkably similar. These programs target children living in families with incomes up to 300 percent of Federal Poverty Level (FPL) who do not qualify for publicly sponsored programs. The two primary target groups are low-income, undocumented children and children living in families with incomes between 250 percent and 300 percent of FPL. Each product covers comprehensive medical, dental, vision and mental health benefits with small premiums and cost-sharing requirements based on the Healthy Families program. In each case the new product is being administered by the Local Initiative in the Two-Plan Model, which serves as the sole health plan for these beneficiaries.[12] Each program uses a variety of local public and private funding sources to subsidize premiums for the insurance coverage and builds on the experiences of its predecessors.

Family Care, Alameda County

In 1999, Alameda Alliance for Health (AAH) recognized the need for affordable and comprehensive health and dental coverage for families that did not qualify for public programs. AAH developed, administers, and subsidizes Alliance Family Care, a managed care insurance product for eligible Alameda County families. AAH worked with representatives of community clinics and other community representatives to ensure that Alliance Family Care was accessible to low-income families. With input from these groups, AAH developed a simple application process. Based on data from the County of Alameda Uninsured Survey (CAUS), there are an estimated 9,500 uninsured children living in families with incomes up to 300 percent of FPL who do not qualify for Medi-Cal or Healthy Families in Alameda County.[13]

Alliance Family Care was launched in July 2000. Family Care provides comprehensive health and dental benefits, similar to Healthy Families, for children and their parents, with minimal premiums and cost-sharing requirements. Health care services are provided through the AAH provider network. Dental services are provided through the Alliance's contract with Delta Dental. AAH has provided $14.6 million from its reserve fund, the county recently agreed to contribute $1 million from its share of the national tobacco settlement, and the California Endowment awarded a $400,000, 2-year grant to help pay for premiums for undocumented children. AAH conducted outreach through clinics, health fairs, the Social Services Agency, and job placement centers to inform eligible families. To date, more than 1,500 children have enrolled, exceeding initial projections.

Healthy Kids, Santa Clara County

In July 2000, the Santa Clara County Board of Supervisors, Working Partnerships USA, and People Acting in Community Together established a goal to ensure that 100 percent of children residing in Santa Clara County will have access to quality health care through comprehensive

health insurance.[14] To achieve this goal, the county expanded outreach and enrollment efforts and introduced Healthy Kids, a subsidized, private insurance product for children who do not qualify for Medi-Cal or Healthy Families.

Approximately 71,000 children in Santa Clara County lack health insurance.[15] Of these children, about 51,000 (72 percent) may be eligible for Medi-Cal or Healthy Families. Approximately 20,000 children may not be eligible for either program because their family income is too high or because of their immigration status.[16] Uninsured children under age 19 who live in Santa Clara County, have family income of less than 300 percent of FPL ($51,150 for a family of four in 2000), and do not qualify for Medi-Cal or Healthy Families are eligible to enroll in Healthy Kids. The benefits, premiums, cost sharing, and provider network have been adapted from Healthy Families. The product is administered by the Santa Clara Family Health Plan (SCFHP). Healthy Kids charges small monthly premiums and copayments for selected services. The $14- to $16-million annual budget to subsidize Healthy Kids premiums has been partially funded through a combination of national tobacco settlement funds from the county and San Jose, contributions from the SCFHP and grant funds from the Proposition 10 Commission, the David and Lucille Packard Foundation, and other foundations and corporations. With funding from the Packard Foundation, the SCFHP also has created a fundraising office. As of December 31, 2001, 8,400 children had enrolled in Healthy Kids.

Healthy Kids, San Francisco County

In January 2002, the San Francisco Health Plan (SFHP) launched a new insurance product, Healthy Kids (HK-SF). With strong support from Mayor Willie Brown and the San Francisco Coalition for Healthy Kids, San Francisco County developed a product to cover low- and moderate-income children who do not qualify for Medi-Cal or Healthy Families. An estimated 5,000 uninsured children are not eligible for either program based on family income and immigration status. Uninsured children under age 19, who live in San Francisco County, have family incomes of less than 300 percent of FPL ($51,150 for a family of four in 2000), and do not qualify for Medi-Cal or Healthy Families will be eligible to participate in HK-SF.

HK-SF is also modeled after the Healthy Families program. The benefits, premiums, cost sharing, and provider networks have been adapted from Healthy Families. HK-SF charges small monthly premiums and copayments for selected services. The $4-6 million annual budget to subsidize premiums is funded exclusively through City General Revenues and a small grant from the County Proposition 10 Commission.

Key Components of Expansions for Children

Outreach

Alameda and Santa Clara Counties have developed major outreach campaigns to identify, educate, and attract potentially eligible children (Table 2). These efforts have been linked to Medi-Cal and Healthy Families in an effort to create seamless coverage for all children living in families with incomes under 300 percent of FPL. All three counties have developed simple messages, program names, and attractive logos to market their programs to low-income families. The primary marketing message is that every child under 300 percent of FPL will be eligible for coverage regardless of their immigration status.

Alameda and Santa Clara launched their programs with "in-reach" campaigns, which targeted uninsured children who were already accessing public hospitals, public clinics, and community health centers to inform them of the new product. Once the in-reach phase was completed, they launched outreach campaigns through schools, health facilities, and community-based organizations. As a result of the innovative nature of their efforts, these counties have received considerable free coverage from the local media to support outreach activities. Learning from experiences in Alameda and Santa Clara, San Francisco launched its product with an extensive media campaign to generate interest and name recognition. After HK-SF completes its initial media campaign, they will conduct in-reach at safety net providers later in 2002.

For a number of reasons, it is important to collect information on the target population for the intervention. This information allows program officials to target their outreach efforts, and it allows policymakers to measure whether the program is reducing the number of uninsured children in the county or not. To gain a better understanding of its target population, Alameda County commissioned researchers at UCLA to conduct the County of Alameda Uninsured Survey (CAUS) to identify the characteristics of the uninsured.[17] In contrast, San Francisco and Santa Clara Counties have relied on county-level data from the Current Population Survey (CPS) to estimate the number of uninsured children. The CPS, however, does not contain precise population data at the county level about the number of uninsured children over time, and so cannot be used by these counties to assess progress toward their objectives.

Enrollment

All three counties have developed simplified two-page applications for their new insurance product. In Santa Clara, the SCFHP, Social Services Agency, Valley Community Outreach Services, and community-based outreach staff all can enroll children in Medi-Cal, Healthy Families, and Healthy Kids. From the county's perspective, there are strong financial incentives to maximize the number of children enrolled in Medi-Cal and Healthy Families because the county receives an infusion of federal and state funding to pay for each child enrolled in these programs. In contrast, the county collaborative or the Local Initiative is responsible for obtaining funding to pay for the majority of the premiums for each child enrolled in the county program. As a result, outreach workers have been trained to screen all children for Medi-Cal or Healthy Families before enrolling them in the local product. In each county, the Local Initiative has taken the lead on the enrollment process for expansion programs.

Evidence from Alameda and Santa Clara counties suggests that the county programs have much higher application success rates than either Medi-Cal or Healthy Families. The application success rate for Healthy Kids in Santa Clara is 98 percent compared to a 78 percent success rate for Healthy Families applications from the county. This difference may be attributable to a combination of the philosophy of the programs, the documentation requirements, a simplified enrollment process, and the individual attention received by each applicant.

Another important policy question for counties is whether county expansions will stimulate greater enrollment in Medi-Cal and Healthy Families. If so, then county funds invested in these programs will generate additional coverage and draw down additional federal and state dollars. Based on evidence from other states, extending coverage to parents should stimulate greater enrollment of children in Medi-Cal and Healthy Families. The Urban Institute found that the Medicaid participation rates for children are much higher (81 percent) in those states that

implemented family coverage under Medicaid than those states that did not (57 percent).[18] Preliminary analysis of enrollment data from Santa Clara County has generated mixed results about whether the presence of Healthy Kids has stimulated greater enrollment in the other programs relative to other counties with similar demographic and health system profiles.[19] Further analysis of the potential "spillover" effect is needed to assess the true cost-effectiveness of these expansion efforts.

Access

As noted above, all three counties have adopted comprehensive benefit packages that are modeled on the Healthy Families program to promote access to medical care, dental and vision care, and mental health services. In Alameda and San Francisco Counties, health plan staff call new applicants after their application has been submitted to ensure that they are enrolled and to encourage them to visit their primary care provider. SFHP and AAH staff make appointments with the child's primary care provider if the family is experiencing difficulty. Recently, the Health Trust in Santa Clara County conducted a telephone survey of newly enrolled parents and found that an astonishing 95 percent of children had seen their primary care provider during the first 90 days of coverage.[20] However, limited data are publicly available at the county or health plan level to assess the relationship between coverage expansions and the use of health care services. AAH periodically monitors the number of individuals who have not used any services and patient complaints in its information system to identify access problems.

Retention

The most common measure of retention is the percentage of individuals who are still enrolled 12 months after signing up for the program. HK-SF is still too new to have collected meaningful retention data, as children have not been enrolled for a full year yet. To date, Family Care has experienced impressive retention, reporting that 5 percent of beneficiaries disenrolled from the program during the annual renewal process. This rate is significantly better than Healthy Families, where 24 percent are no longer enrolled, and Medi-Cal, where 63 percent of low-income families are no longer enrolled. All three counties have implemented features designed to support retention of benefits over time. Santa Clara and San Francisco have created premium assistance funds to subsidize the family share of the premium in case of hardship. Unlike Healthy Families, if parents do not respond to bills for premiums, then their premiums are covered for two months while outreach staff attempt to contact them. Like Medi-Cal and Healthy Families, children only have to re-establish their eligibility one time each year. To minimize the administrative burden of premium payments, San Francisco will implement a quarterly billing system for HK-SF so that parents only need to make four premium payments per year. San Francisco also offers parents the opportunity to pay premiums for nine months at enrollment in order to receive one year of coverage.

Sustainability

Although these efforts have been funded through county and private sources, the state's budget crisis is likely to negatively impact their sustainability. It is widely expected that state funding of county health budgets will decrease during the next budget cycle through reductions in transfers from the state vehicle license fee. If the expected reductions occur, county elected officials will face considerable political pressure to shift public funds such as general revenues and national tobacco settlement from these coverage expansions to existing programs that experience

shortfalls. In addition, Governor Davis has proposed the elimination of the Children's Health and Disability Prevention (CHDP) program, which is an important source of funding to pay for services provided to uninsured children.

In December 2001, Governor Davis signed a bill that creates the potential to secure federal matching funds for county health insurance initiatives in the future. AB 495 will create a Children's Health Initiative Matching Fund to provide local agencies with federal matching funds to cover children who live in families with incomes below 300 percent of FPL but do not qualify for Medi-Cal or Healthy Families. Under the law, the state will submit another 1115 waiver request to the federal government to apply the unused portion of Healthy Families funds as matching funds for counties. This waiver will not be submitted until after CMS approves the parental waiver under consideration. Given that the majority (82 percent) of children enrolled in Healthy Kids are undocumented, it is not likely that AB 495 will provide substantial federal matching funds under current law. In light of the delay in the implementation of the initial Healthy Families waiver, this legislation is largely symbolic in the short-term.

Expanding Coverage for Uninsured Adults

Compared to the children's expansions, there is much greater variation among expansions for uninsured adults. All four programs have attempted to organize the delivery and financing of care to uninsured adults. Contra Costa and Solano Counties have pooled existing funds to create a managed care product for indigent adults. Alameda Alliance for Health used its reserve funds to create a subsidized insurance product, Alliance Family Care, for uninsured parents. Finally, San Joaquin General Hospital and San Joaquin Health Plan collaborated to create a pilot program that provides improved access to medical services at a county hospital. In all four counties, there is an expectation that some participants will be transferred to Healthy Families once the waiver is approved and implemented. The Healthy Parents program in San Joaquin was created explicitly as a transitional program until the implementation of the parental waiver.

Basic Adult Care, Contra Costa County[21]

In 1983, Contra Costa County introduced Basic Adult Care (BAC) to provide health insurance coverage to an estimated 9,000 uninsured adults between 21 and 64 who earn less than $24,000 per year ($32,100 for a couple) and are eligible for the Medically Indigent Service Program (MISP).[22] The managed care plan includes prescription drugs, inpatient, outpatient, and home health care. Premiums are assessed on a sliding scale based on an individual's income. They range from $0 to $225 per quarter, but the vast majority of BAC members (88 percent) pay no premiums. No copayments or deductibles are charged once a person is enrolled.[23]

BAC functions as a staff model HMO administered by the Contra Costa Health Plan (CCHP). Members must receive outpatient care at one of eleven county health centers and inpatient care from the county hospital. About 4,000 adults participate in BAC.[24] The estimated cost of all programs serving uninsured adults is $29 million annually with $19.5 million coming from state and the remaining $9.5 million from county general funds, Proposition 99, and realignment funds. BAC operates as the financing mechanism of last resort so very limited outreach has been conducted among the homeless population, and enrollment takes place at the point of service.

Family Care, Alameda County

In 1999, in an effort to expand coverage among the 11,000 low-income uninsured adults, the Alameda Alliance of Health (AAH) created a subsidized insurance product targeting uninsured parents of children who were undocumented or in Healthy Families or Medi-Cal. In July 2000, AAH introduced the new product, Family Care, for parents who have a child enrolled in AAH through Medi-Cal, Healthy Families, or Family Care. Alameda is the only county to expand coverage for both children and adults.

AAH provides the bulk of funding to subsidize premiums using money from its reserve fund. Adults pay discounted, age-adjusted premiums. They range from less than $10 per month for adults under 19 to $120 per month for adults aged 60 to 64. Family Care offers comprehensive health and dental benefits that are similar to the Healthy Families Program for adults and are delivered through AAH's provider network. This coverage is medically underwritten, although AAH reports that only a handful of individuals have been denied coverage because of a medical condition. Over the past year, AAH has conducted outreach through clinics, health fairs, social services agencies, and job placement centers to inform the eligible families about the program. To date, 3,100 adults have enrolled in Family Care.

Healthy Parents, San Joaquin County

In September 2000, San Joaquin Health Plan (SJHP) and San Joaquin General Hospital (SJGH) implemented Healthy Parents, a pilot program to increase access to health care services for uninsured parents of Healthy Families beneficiaries.[25] The program began in August 2000 with the objective of improving access to care for 1,000 adults until the implementation of the state's Healthy Families waiver. The enrollment target was achieved within two months and is now capped at 1,010. Although Healthy Parents is not an insurance program, it is administered by SJHP. All health care services are provided exclusively through SJGH and its affiliated clinics. Vision, dental, and mental health care are not covered. No premiums are charged, but participants are required to make copayments for emergency room visits, outpatient services, prescription drugs, and inpatient services up to a maximum of 10 percent of their monthly income.

The total annual cost of Healthy Parents was estimated to be $1 million. Initially, SJHP contributed $750,000 and SJGH contributed $250,000 to launch the program. Healthy Parents was designed as a one-year program that was scheduled to end in August 2001. Due to delays in the approval of the state waiver, there is still a need for the program in the county. SJGH, SJHP, and the Board of Supervisors have agreed to continue the program using unspent funds from the pilot year until July 2002. In September 2001, the county received a Community Access Program (CAP) grant from the U.S. Health Resources and Services Administration (HRSA) that will enhance their management information systems (MIS) for appointments, referrals, and care management.

County Medical Services Program (CMSP) Redesign, Solano County

In February 2002, Solano County is scheduled to implement its CMSP redesign. In 1999, the Solano Coalition for Better Health raised the issue of poor access to care for low-income, uninsured adults in the county. They convened a focus group with executive directors of the hospitals and community clinics to discuss the issue of access. They found that individuals who participated in the County Medical Services Program (CMSP) had difficulty finding doctors who

would accept it. As a result, Solano County petitioned the state to convert funds that it had received under CMSP into an insurance product for it low-income uninsured adults. The state agreed to a one-year pilot program. Between 2,600 and 2,800 indigent adults between 21 and 64 who do not qualify for no-cost Medi-Cal but are eligible for no-cost CMSP will be eligible for the new pilot program. An individual must earn less than $8,300 annually to qualify for no-cost CMSP. The benefits will be similar to Medi-Cal, excluding pregnancy-related services, long-term care, and ancillary services. In addition, a separate grant from CMSP will pay for case management for chronic illnesses, mental health, and substance abuse.

Partnership HealthPlan of California (PHC), a County Organized Health System (COHS) that finances health care in Solano, Napa and Yolo Counties, will administer the program. PHC will contract with Medi-Cal primary care providers, specialists, and hospitals. The county will use existing CMSP funds to pay for the redesigned program. In 2000-01, Solano County's CMSP spent $14.5 million ($7.5 million state and $7.0 million county) on inpatient and outpatient care. Funding for the Redesign pilot is capped at $10 million for the year. The state will continue to pay for services provided to share-of-cost CMSP recipients on a fee-for-service basis. The Department of Health is soliciting grant funds to pay for additional case management services provided under the program. The state plans to evaluate the program after eight months of implementation to determine whether it should be continued based on a number of criteria, including cost effectiveness.

Key Components of Expansions for Adults

Outreach

In contrast to children's expansions, outreach for adult expansion has been limited for several reasons. In all four adult programs, the target population already had some connection to the local health system either through their children's coverage, participation in medically indigent programs, or use of services. Unlike Medi-Cal for children and Healthy Families, there are very limited outreach funds available to promote coverage among adults in the absence of the Healthy Families waiver. BAC in Contra Costa and the CMSP Redesign in Solano were created from programs that served as the last resort for uninsured adults who have no other options. As a result, outreach staff for adult programs are only a fraction of the size of those used to market children's programs. Solano and San Joaquin contacted potentially eligible individuals directly to inform them of the new program and facilitate their participation. This communication strategy appears to have been successful; the Healthy Parents program in San Joaquin County reached its maximum capacity after only two months in operation. Of the programs targeting adults, only AAH has conducted outreach in the community to market its new product.

Enrollment

Typically, the enrollment process for adult programs is very simple and involves the completion of a brief application or receipt of a letter deeming eligibility. In Solano County, PHC mailed letters to all eligible individuals participating in no-cost CMSP to inform them of the change in benefits. The letter contained a packet of information about the program and asked them to choose a primary care provider. If the participant does not responded within 30 days, he or she will be automatically assigned to a primary care provider. New CMSP applicants will continue to complete the CMSP application. The majority of applications for Family Care have been

completed at AAH in Alameda County, reflecting the limited scope of their outreach efforts. The BAC program has created the simplest enrollment process, enrolling new beneficiaries at the point of service when they access county facilities.

Access to Care

A major objective of all four adult expansions was to improve access to health care services. As a result, they have employed a number of strategies to facilitate access to care and monitor use of services. As noted above, AAH provides assistance with scheduling appointments during a welcome phone call. CCHP assigns every BAC member to a primary care case manager who coordinates their care while they are enrolled. PHC scheduled meetings with local physicians in Solano County to encourage them to accept patients under the CMSP Redesign program so that new beneficiaries would have an adequate choice of physicians. As mentioned above, AAH collects monthly utilization data for members. These data allow AAH to identify members who have not used any services, which may indicate problems with access. Similarly, SJGH has collected extensive utilization and cost data to monitor access to care. In the first year, they found that half the enrollees (50 percent) had used outpatient services and only 2 percent had used inpatient services. This figure is lower than inpatient utilization by adults enrolled in Medi-Cal. CCHP reports reductions in the number of emergency room visits by BAC members.

Retention

Of the four programs, only Family Care has developed a re-enrollment system. AAH sends a one-page letter to families before the anniversary date. The family must verify that information is correct and return it. AAH reports that only 5 percent of beneficiaries disenrolled at 12 months. The other three programs have not addressed the issue of retention directly. Members are disenrolled from the BAC program if they do not use services during a six-month period, but they can reenroll in the program the next time they access a county health facility. This policy and the point-of-service enrollment process have led to churning of coverage. Healthy Parents was created as a one-year transitional program without premiums and did not anticipate the need to redetermine eligibility. Finally, the CMSP Redesign will retain the quarterly redetermination policy of Medi-Cal, which is a primary cause of disenrollment.

Sustainability

To varying degrees, all four programs are looking forward to the implementation of the Healthy Families waiver as they anticipate that a portion of their participants will be transferred to Healthy Families. Nearly all Healthy Parents participants should be eligible for Healthy Families as long as their children continue to be enrolled in either Healthy Families or Medi-Cal. Many adults enrolled in Family Care could be transitioned to Healthy Families as well. It is likely that a much smaller percentage of enrollees in the CMSP Redesign and BAC would be eligible considering their demographic profiles. The delay of the implementation of the Healthy Families waiver until 2003 will have negative financial implications for Healthy Parents and Family Care. Local and private funds will be required to sustain them in the short-term. In contrast, the CMSP redesign and BAC program receive significant funding from the state budget. As a result, these programs are more vulnerable to funding cuts in Medi-Cal and realignment dollars generated from state vehicle license fees.

Other Public and Private Efforts

Although the six counties described here are leaders in the state, many other public and private efforts to increase coverage and expand access to health care for the uninsured population exist in the state. For example, the San Diego Kids Health Assurance Network (SD-KHAN) collaborates with several primary care medical groups to offer free primary care services to uninsured children who are not eligible for Medi-Cal or Healthy Families. As of September 2001, the volunteer physician program had provided free primary care to more than 200 uninsured children at a cost of $22,000. Due to the limited number of participating providers, however, more than 150 children are waiting for services and the program is limited to primary care visits. San Diego County also drafted a comprehensive strategic plan to expand and coordinate its outreach and enrollment efforts with local businesses that employ large numbers of uninsured workers. The county submitted a bill to the legislature (AB 1547) that would have established a comprehensive outreach program between businesses and the county at an annual cost of $2.5 million for the two-year demonstration project. The state legislature passed the bill but Governor Davis vetoed it.

Using funds from a federal CAP grant, Orange County has initiated a planning and consultation process to develop subsidized insurance products for uninsured adults and children. The county anticipates the introduction of a subsidized insurance product for uninsured children in 2002 and for uninsured adults in 2003 through CalOPTIMA, the County Organized Health System. Several counties in the Bay Area have expanded health insurance coverage for In-Home Support Services (IHSS) workers through the Local Initiative's network. Alameda, Contra Costa, San Francisco, and Santa Clara all offer coverage to IHSS workers through the Local Initiative health plan, using a mix of tobacco settlement funds, county funds, and federal and state revenues. The 2001-02 state budget provides $31.4 million to increase the state's share of employee wages and benefits for IHSS providers.

In addition to public efforts, four private health plans in the state have initiated programs designed to cover working poor adults and their children.[26] CaliforniaKids and Kaiser Permanente offer subsidized private health insurance coverage to low- and moderate-income uninsured children throughout the state. The Sharp Health Plan and the Community Health Group in San Diego both target uninsured, working adults for coverage. Sharp FOCUS is a pilot program that offers subsidized coverage to small businesses that do not offer health insurance, funded by the Alliance Health Foundation, California HealthCare Foundation, and the California Endowment. Enrollment in all of these programs is modest, suggesting that they offer only partial solutions to the issue of uninsured workers.

State Initiatives Impacting These County Efforts

In December 2000, the state of California submitted a waiver proposal to the Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration [HCFA]) to expand the Healthy Families program to cover uninsured parents of children enrolled in Healthy Families. The state estimated that 300,000 parents with incomes under 200 percent of FPL would participate in the program when the program reached its full

capacity based on current federal funding. Under the state's proposal, parents would be eligible to enroll in the Healthy Families program for a heavily discounted premium.

From enrollment and financial perspectives, the implementation of the Healthy Families waiver has many important implications for county health programs. If approved, it will allow the state to expand coverage to a large group of uninsured adults. A recent study by the Urban Institute found that more than one in three (37 percent) uninsured parents of children eligible for Medicaid or State Children's Health Insurance Program (called Healthy Families in California) did not have a usual source of care, compared to 17 percent of parents covered by Medicaid.[27] More than one-half (51 percent) of uninsured parents had not seen a physician in the past year, compared to 29 percent of parents with Medicaid.[28]

The Healthy Families waiver also played a critical role in the strategic planning of county officials. Coverage expansions were initiated with the expectation of securing significant, long-term state and federal funds. Several county programs described in this paper were developed based on the assumption that the parental waiver would be approved and participants would be transitioned into Healthy Families. Thus, these county efforts will be influenced by CMS's decision regarding California's waiver proposal and its subsequent implementation. If the waiver is not implemented until 2003, counties that have developed "bridge programs" for low-income parents will need to reconsider whether they can sustain them without additional federal and state resources.

There is continuing uncertainty about the timing of the implementation of the waiver. In November 2001, Governor Davis proposed to delay implementation of the waiver until July 2003 even if it was approved before then. In January 2002, CMS requested that the state resubmit its waiver in the new Health Insurance Flexibility and Accountability (HIFA) Initiative format. CMS officially approved California's HIFA waiver application on January 25, 2002. Governor Davis then announced his desire to begin implementing the waiver in July 2002 if the legislature could find sufficient funds in the state budget to fund the state's share. The final implementation date for the waiver will be determined during the current legislative session.

It is important to remember that these discussions are taking place against the backdrop of an expected $12 billion budget shortfall for the 2002-03 fiscal year. It is expected that state funding of county health budgets will decrease during the next budget cycle through reductions in transfers from the state vehicle license fee. If the expected reductions occur, county elected officials will face considerable political pressure to shift public funds such as the national tobacco settlement from these coverage expansions to existing programs that experience shortfalls.

Lessons Learned

Experiences in these six counties provide some important lessons for other counties and the state.

- **In the absence of federal and state leadership, counties can take action to reduce the number of uninsured individuals.**

  These six initiatives demonstrate that with sufficient political will and significant financial resources, counties and cities do not have to wait for changes in federal and

state policy to expand health insurance coverage. The state and counties already spend considerable amounts on health care provided to the uninsured. These funds can be reprogrammed to purchase health insurance. The National Tobacco Settlement and California tobacco tax revenues generated by Proposition 10 provide substantial extraordinary revenue streams over the next 25 years that can contribute to coverage expansions.

- **County-level solutions are likely to be small in scale and short-term. Thus, state and federal funds are needed to sustain them in the long-term and to expand them.**

  It is not clear that counties can or will sustain these programs without financial support from the state and federal governments. Many decisions appear to be made based on limited funding streams available at the county level. Several counties have capped enrollment for their programs due to funding limitations. Most counties reported that their program was intended to fill in the gaps until state and federal money was secured through the Healthy Families parental waiver or another Section 1115 waiver. When federal waivers are approved and eventually implemented, counties may be able to transfer some responsibility for funding these programs to the federal and state governments. Under current law, however, it will be difficult to obtain federal and state funding to subsidize coverage for undocumented immigrants enrolled in these programs.

- **Sufficient administrative capacity and dedicated funding streams are necessary to develop and implement coverage expansions at the county level.**

  In each case, the Local Initiative or County Organized Health System played an integral role in the development of the expansion effort. These organizations already provide health coverage to Medi-Cal and Healthy Families beneficiaries in the county. Thus, they had experience with the target populations, appropriate provider networks in place, additional revenues to contribute in some cases, and sufficient administrative capacity. Every county but Solano provides health care to indigent populations through a publicly financed delivery system. Thus, they have strong financial incentives to improve the organization of the delivery of care to use resources more efficiently. Several counties received CAP grants from HRSA, which allowed them to plan the expansion programs.

- **Programs that expand coverage using local and private funds have established thorough screening mechanisms to maximize their overall impact and limit the substitution of one type of coverage for another.**

  In order to achieve the greatest enrollment with existing resources, Santa Clara, Alameda, and San Francisco Counties must enroll all eligible children in Medi-Cal and Healthy Families. Otherwise, they will substitute local coverage for federal and state-funded coverage. Preliminary evidence from Santa Clara County suggests that about one-third of children have enrolled in each of the three programs since the inception of Healthy Kids in February 2001 despite the fact that Medi-Cal eligibles represent a much larger share of the county's population of uninsured children. SCFHP reports increases in the number of children enrolling in Healthy Families and Medi-Cal during this period.

- **Evidence from some counties suggests that these county programs have much higher application success rates than either Medi-Cal or Healthy Families.**

Preliminary data from Alameda and Santa Clara counties suggest that more children who apply for the local program are successfully enrolled. There are many potential explanations for the higher success rate for these programs, including a shorter application form, less documentation, greater assistance in completing the application, and better follow-up of incomplete applications. However, it is difficult to determine the causes without a formal evaluation.

- **Given the current pessimistic outlook for the state budget and the uncertainty of the implementation of the Healthy Families waiver, the short-term sustainability of these county expansions is uncertain.**

  Programs that have tapped into extraordinary resources such as Alameda, San Joaquin, and Santa Clara Counties' may see increased competition for these funds during the next fiscal year. On the other hand, programs that have relied on realignment dollars, such as Contra Costa and Solano Counties, are vulnerable to reductions in state funds such as state vehicle fees, which are transferred to counties to fund indigent health care services. San Francisco's program may have to compete with numerous other local programs for funding because it is funded through the City's General Fund. Program officials in all counties indicated that they are very committed to continuing these efforts, but the priorities of county policymakers change with the economic climate.

- **These incremental efforts to expand coverage highlight the differential financial impacts of direct funding of safety net providers versus the subsidization of health insurance.**

  Despite their innovation, the efforts described here tend to be modest in scope. None fully addresses the problem of the uninsured. As a result, each county and the state must continue to fund safety net providers for care that is provided to the uninsured at the same time they are funding coverage expansions. This situation highlights the complexity of the current health care financing system for low-income individuals. Due to the low reimbursement rates paid by the children's insurance products, safety net providers have expressed concern about the long-term impacts of coverage expansions. Since these programs are small in scale and help their patients, providers have been supportive thus far. It remains to be seen, however, whether they would support large-scale expansions or efforts to replicate these programs statewide using the current reimbursement levels.

- **None of the county programs has involved private health plans in the development or implementation of these programs. This omission could have practical and political implications if they are expanded or replicated statewide.**

  Each county made a strategic decision to rely on public health plans to administer their new products and programs, largely excluding commercial health plans. In particular, the three counties that have expanded coverage for children have not collaborated with the two major private insurance programs targeting low-income children, CaliforniaKids and Kaiser Permanente Cares for Kids I and II. As a result, public subsidies may be used to substitute for private coverage. As public expansions target individuals at higher income levels, there is also greater potential to "crowd out" private coverage. If these programs were further expanded, commercial health plans might be expected to lobby increasingly for a role in the financing and delivery of services to the newly insured.

Table 1: Summary of Outreach, Enrollment, Access, and Retention Efforts

County and Program	Start Date	Target Population	Enrollment	Funding	Benefits and Cost-Sharing	Administering Agency	Provider Network
Children's Expansions							
Alameda: **Family Care**	July 2000	9,500 uninsured children living in families with incomes up to 300% of FPL who do not qualify for Medi-Cal or Healthy Families	Over 1,500 children enrolled	$14.6 million has been committed from Alameda Alliance reserve fund. The Board of Supervisors committed $1 million from the national tobacco settlement. The California Endowment gave a $400,000 grant to subsidize premiums for undocumented children.	Comprehensive health, dental and mental health benefits are covered with minimal premiums and cost-sharing.	Alameda Alliance for Health (AAH)	AAH network and Delta Dental network
Santa Clara: **Healthy Kids**	January 2001	Approximately 14,000 children under 300% FPL ($51,000 for a family of four) who are not eligible for Medi-Cal or Healthy Families	8,429 children enrolled as of December 2001.	$14-$16 million budget has been set to subsidize premiums. Program has received commitments from County and San Jose national tobacco settlement funds, Proposition 10, Packard Foundation, and SCFHP Foundation.	Benefits and cost-sharing are similar to Healthy Families program. Medical, dental, vision, and mental health care are covered.	Santa Clara Family Health Plan (SCFHP)	SCFHP Medi-Cal and Healthy Families Network
San Francisco: **Healthy Kids Program**	January 2002	An estimated 5,000 uninsured children with incomes between 0%–300% of FPL who do not qualify for Medi-Cal or Healthy Families.	Enrollment began 1/2/02.	$5.7 million total budget Received county general funds and Proposition 10 funds. Applied for special sales tax, and Local Prop D funds	Benefits and cost-sharing are slightly lower than Healthy Families program. Medical, dental, vision, and mental health care are covered.	San Francisco Health Plan (SFHP)	SFHP Healthy Families network

Table 1: Summary of Outreach, Enrollment, Access, and Retention Efforts (continued)

County and Program	Start Date	Target Population	Enrollment	Funding	Benefits and Cost-Sharing	Administering Agency	Provider Network
Adult Expansions							
Alameda: **Family Care**	July 2000	11,000 uninsured adults with incomes below 200% of FPL.	3,100 adults enrolled.	$14.6 million has been committed from Alameda Alliance reserve fund; Board of Supervisors committed $1 million from the national tobacco settlement. Beneficiary premiums.	Health, dental and mental health benefits similar to the Healthy Families Program. Discounted premiums are age-adjusted $10 per month under 19 to $120 per month for 60-64. Policy is medically underwritten.	Alameda Alliance for Health (AAH)	AAH network and Delta Dental network
Contra Costa: **Basic Adult Care**	1983	Estimated at 9,000 Uninsured adults between 21 and 64 who earn less than $2,000 per month individually or $2,677 as a couple. Eligible for MISP program.	Approximately 4,000 adults	$12 million per year; 2/3 from state and 1/3 from county general funds, Proposition 99, and realignment funds.	Commercial insurance product includes prescription drugs, inpatient, outpatient, and home health care. Sliding premiums based on income from $0 to $225 per quarter. 88% pay $0. No copayments or deductibles are charged.	Contra Costa Health Plan (CCHP)	Staff model HMO limited to county facilities. Outpatient care provided at eleven county health centers and inpatient at county hospital.
San Joaquin: **Healthy Parents**	July 2000	Parents of children enrolled in Healthy Families. Medi-Cal share-of-cost individuals were excluded.	1,010 adults Maximum capacity was reached two months after inception. Enrollment is capped.	$1 million; $750,000 from San Joaquin Health Plan and $250,000 from San Joaquin General Hospital. $12,000 collected in copayments.	All health care services available through San Joaquin General Hospital. No premiums. Copays are required for ER, outpatient, and prescription drugs up to max. 10% monthly income. No vision, dental, mental health.	San Joaquin Health Plan (SJHP)	San Joaquin General Hospital only.
Solano: **CMSP Redesign**	Feb. 2002	2,600 to 2,800 indigent adults between 21 and 64 in CMSP, who do not qualify for no-cost Medi-Cal.	Not started yet.	Pilot program capped at $10 million for year ($7 million county, $3 million state). State will continue to fund share-of-cost CMSP on a fee-for-service basis. Separate CMSP grant pays for case manage-ment services.	Similar to Medi-Cal with the exception of pregnancy-related services, long-term care, and ancillary services. Case management for chronic illnesses and mental health and substance abuse.	Partnership HealthPlan of California (PHC)	PHC will contract with Medi-Cal primary care providers, specialists, and hospitals.

Table 2: Summary of Outreach, Enrollment, Access, and Retention Efforts

County and Program	Outreach Efforts	Application Process	Activities to Ensure Access to Care	Utilization Data	Duration of Program/ Coverage	Retention Plan	Evaluations
Children's Expansions							
Alameda: **Family Care**	Started with in-reach campaign through community clinics. Participate in health fairs. Considerable free media coverage. Have not had to 0conduct direct mail campaigns because enrollment targets have been met.	Two-page application for Family Care. One-page medical questionnaire for adults. Very high success rate for applications. Poor reporting system to track the status of applications. Most enrollments take place at AAH.	Welcome calls to every family. Provide assistance scheduling an appointment.	Collect utilization data by members monthly to identify members who have not used services. AAH is considering HEDIS standard that newly enrolled be seen in first 120 days.	Program is ongoing and enrollment is renewed annually.	Alliance sends a one-page letter to families before anniversary date. Family must verify that information is correct and return to AA. They report that only 5% of beneficiaries disenrolled at 12 months. They are planning to develop a premium assistance fund.	Three evaluations are under way by researchers at the University of Michigan and Mathematica with funding from RWJ and CHCF to look at (1) customer satisfaction, (2) finances, and (3) impact. AAH is conducting evaluation of outreach activities.
San Francisco: **Healthy Kids Program**	SFHP started with media campaign to raise awareness. Will conduct in-reach campaign at clinics. Will use Bringing Up Healthy Kids Coalition to conduct outreach activities at schools, churches, etc. SFHP has increased outreach staff.	Two-page application for Healthy Kids. Screen for enrollment in Medi-Cal and Healthy Families before enrolling in Healthy Kids. Application assistance will be available in community and SFHP.	SFHP calls every family between 60 and 90 days after enrollment. Staff assists families in making first appointment, if necessary. SFHP monitors wait times for an appointment.	Program has just begun so there is no utilization data at this time. SFHP plans to use some HEDIS measures to evaluate utilization.	Program will be ongoing and enrollment will be renewed annually.	To reduce number of correspondences, SFHP will bill quarterly at the beginning of the period. Developing a premium assistance fund.	No evaluations are planned at this time.

Table 2: Summary of Outreach, Enrollment, Access, and Retention Efforts (continued)

County and Program	Outreach Efforts	Application Process	Activities to Ensure Access to Care	Utilization Data	Duration of Program/ Coverage	Retention Plan	Evaluations
Children's Expansions (continued)							
Santa Clara: **Healthy Kids**	Started with an in-reach campaign for two months at clinics and hospitals. Outreach coordinated by increased SCVHHS staff.	Two-page application for Healthy Kids. Screen for enrollment in Medi-Cal and Healthy Families before enrolling in Healthy Kids. Enrollment assistance provided at multiple agencies. SSA will assist with Healthy Kid applications.	Some community-based organizations call newly enrolled families to encourage them to access services.	No utilization data for Healthy Kids is available due to problems in the county's information system.	Program is ongoing and enrollment is continuous.	Program has not been operational for one year yet. SCFHP established a premium assistance fund for parents that cannot afford premiums. Try to reach parents for two months before disenrolling children.	Process evaluation conducted by UCSF. Institute for Health Policy Solutions. Planning grant awarded to Mathematica Policy Research by the Packard Foundation to prepare for an impact evaluation.
Adult Expansions							
Alameda: **Family Care**	In-reach campaign through community clinics. Some health fairs. Considerable free media coverage. Have not had to conduct direct mail campaigns because enrollment targets have been met.	Two-page application for family care. One-page medical questionnaire for adults. Very high success rate for applications. Poor reporting system to track the status of applications. Most enrollment takes place at Alliance.	Welcome calls to every family. Provide assistance scheduling an appointment.	Collect utilization data by members monthly, which notes if a member has not used services. They are considering HEDIS standard that newly enrolled must be seen in the first 120 days of coverage. Alliance monitors provider behaviors that could limit access.	Program is ongoing and enrollment is renewed annually.	Alliance sends a one-page letter to families before anniversary date. Family must verify that information is correct and return to AA. They report that only 5% of beneficiaries disenrolled at 12 months. They are planning to develop a premiums assistance fund.	Three separate evaluations are being conducted by University of Michigan and Mathematica Policy Research, Inc.

Table 2: Summary of Outreach, Enrollment, Access, and Retention Efforts (continued)

County and Program	Outreach Efforts	Application Process	Activities to Ensure Access to Care	Utilization Data	Duration of Program/ Coverage	Retention Plan	Evaluations
Adult Expansions (continued)							
Contra Costa: **Basic Adult Care**	No formal marketing plan because BAC is considered to be provider of last resort. County workers conduct outreach to homeless population.	Enrollment occurs at the point of service through a financial screener. Six-month enrollment period.	BAC members are assigned to a primary care case manager to coordinate their care.	Evidence of reduced utilization of emergency room by BAC members.	Program is ongoing and enrollment is renewed every six months.	If BAC members do not seek care during the six-month period, their enrollment is terminated. They can reenroll when they seek health care again.	Descriptive evaluation conducted by Andrulis et al. funded by the Commonwealth Fund.
San Joaquin: **Healthy Parents**	Contacted parents of children enrolled in Healthy Families program to notify them of new program. Limited outreach activities with less than 1 FTE.	Staff at SJGH processed four-page application. Few denials, most were because individual had share-of-cost Medi-Cal.	All services are provided at SJGH, which facilitates continuity of care.	SJGH collects extensive utilization and cost data. Less than 50% of enrollees have used outpatient services and 2% inpatient services.	One-year program that was scheduled to end in July 2001. Program has continued, but renewal policy is not clear.	Did not redetermine eligibility at one-year. No premiums are collected. Have not collected information on who is still participating. Few people have dropped out.	Process evaluation conducted by UCSF.
Solano: **CMSP Redesign**	Will begin with an in-reach campaign by contacting current participants in CMSP program to notify them of the change.	No application is used. Letter mailed to CMSP eligible individuals. Must return with their choice of PCP.	Met with local physicians to encourage them to participate in redesign.	Plan to measure: Emergency room use rates. Number of individuals with a medical home.	One-year pilot program that can be renewed.	Still require quarterly status report consistent with CMSP and annual redetermination.	State is planning an evaluation after 8 months to determine its cost-effectiveness.

Notes

1. E. Richard Brown, Ninez Ponce, and Thomas Rice. The State of Health Insurance in California: Recent Trends and Future Prospects. UCLA Center for Health Policy Research. Los Angeles, CA. March 2001.

2. Brown, Ponce, and Rice. 2001.

3. Brown, Ponce, and Rice. 2001.

4. Department of Finance. 2001-02 Governor's Budget Summary. Sacramento, CA. 2001.

5. For more information about enrollment in Healthy Families, AIM, and MRMIP, please visit www.mrmib.ca.gov.

6. Brown, Ponce, and Rice. 2001.

7. Brown, Ponce, and Rice. 2001.

8. Brown, Ponce, and Rice, 2001.

9. Brown, Ponce, and Rice. 2001.

10. Office of County Health Services. Briefing Paper on County Financial Maintenance of Effort and County Health Services Programs. Sacramento, CA: Department of Health Services, October 1999.

11. Because San Francisco County is using City general revenues, which also fund public providers directly, to finance its coverage expansion, its financial incentives are not as clear.

12. The Local Initiative (LI) is a public health plan established under the state's transition of Medi-Cal beneficiaries into managed care. For more information on Medi-Cal managed care and the Two-Plan Model, please see "Medi-Cal Managed Care: A Fact Sheet," which can be found at www.medi-cal.org.

13. Ninez Ponce, Tomiko Conner, B. Patricia Barrera, and Dung Suh. Advancing Universal Coverage in Alameda County: Results of the County of Alameda Uninsured Survey. Los Angeles, CA: UCLA Center for Health Policy Research, 2001.

14. For a more detailed description of the Children's Health Initiative, please see Peter Long, "A First Glance at the Children's Health Initiative in Santa Clara County, California." Kaiser Commission on Medicaid and Uninsured, August 2001.

15. Due to the small sample sizes used to calculate these estimates, the actual number of uninsured children in the county could range from 48,000 to 87,000. Liane Wong. Background Data and Models for Expanding Health Insurance Coverage in Santa Clara

County. Institute for Health Policy Solutions. October 2000. Based on CPS analysis by UCLA Center for Health Policy Research.

16. Wong. October 2000.

17. Ponce, Conner, Barrera, and Suh. 2001.

18. Lisa Dubay and Genevieve Kenney. "Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2001.

19. Unpublished analyses performed by Santa Clara Family Health Plan (SCFHP) have shown that the average monthly enrollment growth rate for total Medi-Cal and Healthy Families is higher for SCFHP than the state average growth rate during 2001. Peter Long, UCLA School of Public Health, found that Los Angeles County, which implemented a comparable outreach campaign to Santa Clara and had a Local Initiative but did not have a separate health product for children such as Healthy Kids, had a higher average enrollment growth in Healthy Families in 2001 than Santa Clara County.

20. Personal communication with M. Moreno, The Health Trust. September 2001.

21. San Mateo County has implemented the WELL program, which is very similar to the BAC program in terms of its target population, eligibility, enrollment procedures, premiums, benefits, and provider network.

22. Denis Andrulis and Michael Gusmano. "Community Initiatives for the Uninsured: How Far Can Community Partnerships Take Us?" New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations. 2001.

23. Andrulis and Gusmano. 2000.

24. Andrulis and Gusmano. 2000.

25. Please note that Healthy Parents is not an insurance program. It was included in this paper because it was designed as a transitional program to improve access to health care for uninsured parents until the Healthy Families waiver was implemented.

26. Lucien Wulsin, Jr. Overview of Public and Private Efforts and Opportunities to Increase Coverage for California's Working Poor. Los Angeles, CA: Insure the Uninsured Project. 1999.

27. Dubay and Kenney. 2001.

28. Dubay and Kenney. 2001.