Step by Step:

Local Coverage Expansion Initiative, Year Two

California HealthCare Foundation

EVALUATION SUMMARY

February 2006

Background

The California HealthCare Foundation (CHCF) funded the Step by Step: Local Coverage Expansion Initiative to assist local organizations as they seek to expand insurance coverage for low-income, uninsured Californians. The goals of Step by Step are to:

- Foster development and implementation of local health insurance programs;
- Encourage efforts to improve and streamline enrollment in local and state insurance programs to maximize resources; and
- Increase the number of insured Californians.

This summary describes the evaluation findings, key lessons, and implications for 2005, the second year of the Step by Step Initiative. CHCF awarded a total of $1.1 million to 13 grantees to plan or implement a coverage expansion in 2005.

Planning grants are for designing and developing a plan for coverage for a targeted population that is ineligible for existing public insurance programs. These grants may be used to strengthen coalitions or prepare financial plans, for example. Six grantees received one-year planning grants of $50,000 or less. Four of these grants focused on expanding coverage for children and two for projects to expand coverage for adults.

Implementation grants are for specific needs associated with launching a local coverage program, such as development of a marketing and outreach strategy or information technology system. Seven grantees received from $90,000 to $145,000 for implementation activities. Six of the grants were for projects to launch insurance programs for children and one for adults.

(Two grantees received funding to assess One-e-App implementation feasibility but they are not included in this analysis.)

Grantees varied in geographic focus, target population, and lead agency and they took different routes to reach similar objectives. The findings are based on data collected from the 13 grantees, including interim and final reports and interviews. Grantees also completed surveys at the beginning and end of the year on skills they already had or needed in planning and implementing an insurance coverage program. See Appendix A for implementation and planning grantees and their target populations, partners, stakeholders, and funding sources.

Program Outcomes

Step by Step grantees reported progress on fronts such as:

- Increasing awareness of the scope of the problem and potential solutions among grantees and other stakeholders;
- Developing and maintaining critical partnerships;
- Identifying and securing new funding; and
- Achieving actual and anticipated enrollment gains for children and adults in new and existing programs.

Overall, grantees improved their ability to design and launch an insurance program, reporting that Step by Step helped either to position them to launch an insurance product or to provide coverage for specific target populations. Because many grantees are part of coalition efforts to expand coverage, the results may be attributable to a variety of organizations and individuals, not solely to Step by Step.

Increasing the Knowledge Base

Step by Step helped all grantees to expand or refine their understanding of local factors that contribute to designing and implementing an insurance product. For some grantees, this meant learning more about a target population, their coverage status, and potential resources. Technical assistance consultants proved valuable in this area, preparing feasibility studies for child and adult coverage options, clarifying benefits and gaps in coverage, and providing financial analyses. Many grantees identified new strategies, such as improved outreach and enrollment efforts or fund development approaches. Regularly scheduled conference calls among grantees helped ensure shared information and resources.

Many grantees convened summits, gave presentations, and launched media campaigns, further sharing knowledge with a wide audience of interested people. This increased visibility and helped to expand and strengthen stakeholder commitment. Grantees also learned more about stakeholder perceptions, such as provider interest in coverage expansions.

Partner Relationships

With Step by Step resources, many grantees were able to persuade some partners to become more active and to engage new partners in the effort to expand coverage. These partners included social service agencies, schools, and unions, among others. Some grantees became more skilled at developing and maintaining partnerships and in better understanding roles and responsibilities among agencies. These lessons are likely to carry over from the planning to the implementation stage.

Many implementation grantees strengthened partnerships between the lead agency and the insurance plan, notably in deciding how premiums would be collected and who was eligible. Grantees in some instances joined with grantees in adjacent communities to expand coverage into both counties for similar populations. For example, San Luis Obispo partnered with the Santa Barbara Regional Health Authority (a county-organized health system) to offer Healthy Kids in both counties. Grantees in other adjacent counties may find similar opportunities in the future to realize economies of scale and to integrate provider networks.

In locales where providers did not perceive a need for insurance coverage or were concerned about payment rates, grantees faced major obstacles in such tasks as building provider networks. New coverage programs in rural areas found it difficult to attract and retain physicians. On the positive side, providers such as safety-net clinics and local hospitals agreed to participate in the coalitions or Children's Health Initiatives (CHIs) in many counties.

Grantees reported that some partnerships were more elusive than others. For most planning and some implementation grantees, finding a health plan partner was difficult, particularly in those counties without a Medi-Cal managed care local initiative or county-organized health system (COHS). Some grantees with small target populations found it especially difficult to attract commercial plans. Five out of six planning grantees nevertheless identified a commercial plan or a Medi-Cal managed care plan as a partner by the end of 2005.

Funding

Grantees reported that Step by Step funding and technical assistance helped them with their own fund development strategies, such as donor campaigns. While most grantees relied primarily on traditional funders (public funding streams and private foundations), some approached or considered other sources such as employers, a special purpose tax, United Way, local foundations, hospitals, and individual donors. Issues persist, including funding premium subsidies for children ages 6 to 18.

Grantees reported that they expect funding for premium subsidies and administrative costs to grow from $6.3 million in 2005 to $10.6 million in 2006, for a total of about $17 million. Grantees targeting children were the most successful in

identifying new funding and expect more than $12.5 million by 2006. Funding for adults varies by target population and lags well behind children, at about $4.6 million, due partly to the smaller number of adult grantees and the lack of public and private funding for adult coverage expansions. Not surprisingly, because their programs are more fully developed, implementation grantees expect to garner the lion's share of funding—almost $16 million, with just more than $1 million going to planning grantees (Table 1).

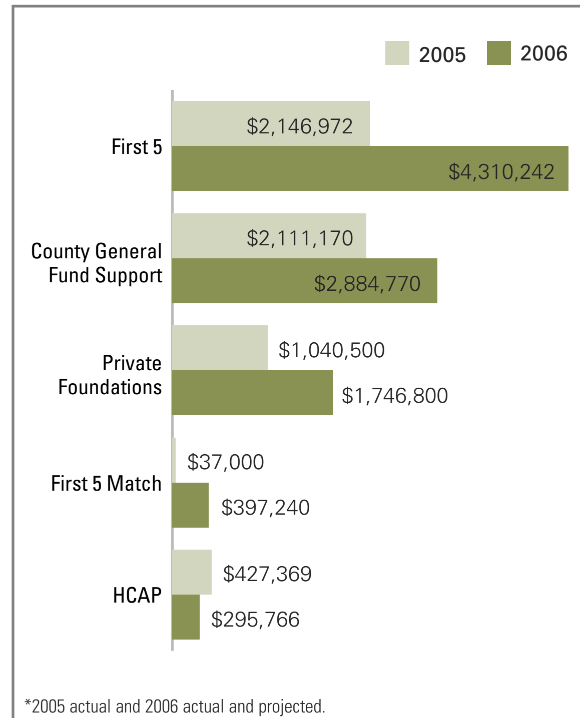
Table 1: Total Funding by Grantee Type*

Child	Planning	$1,330,654
	Implementation	$11,174,275
Adult	Planning	$0
	Implementation	$4,595,940

*2005 actual and 2006 actual and projected.

The largest sources of funding came from First 5 and County General Fund Support. Together, these sources are expected to increase to more than $7 million in 2006. Other public funding such as the state First 5 Match and the federal Healthy Communities Access Program (HCAP; see http://bphc.hrsa.gov/cap) grants came to less than $1.2 million. The California Endowment and other private foundations are becoming more important sources of funds, with contributions expected to nearly double in 2006 from about $1 million in 2005 (Figure 1).

Figure 1: Funding Secured by Source and Year*



*2005 actual and 2006 actual and projected.

Insured Californians

Grantees expect to enroll 21,241 people in total by the end of 2006, slightly less than their original estimate of 24,534 made in early 2005. The lower number is due to delays in enrolling children in some Healthy Kids programs until 2006 and the longer time needed to launch some adult programs.

Most of those newly covered will be children, as grantees estimate enrolling 19,946 children for coverage by the end of 2006. Of the ten grantees targeting children, seven (Fresno, Kings, Merced, San Luis Obispo, Santa Barbara, Sonoma, and Tulare) hope to enroll a total of 5,526 in Healthy Kids.

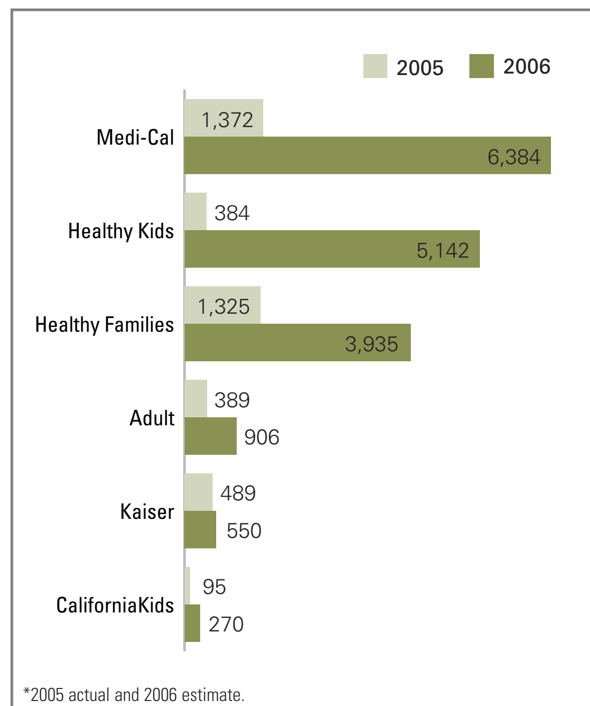
Two of the three grantees targeting adults (Santa Clara and Monterey/Santa Cruz) expect to enroll 1,295 people by the end of this year.

Table 2: Number of Insured, 2005 Actual and 2006 Estimated

	Healthy Kids		CaliforniaKids		Medi-Cal		Healthy Families		Kaiser		Adult		
GRANTEE TYPE	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2-YEAR TOTAL
Planning	0	1,100	0	100	840	3,880	319	1,838	0	0	0	500	8,577
Implementation	384	4,042	95	170	532	2,504	1,006	2,097	489	550	389	406	12,664
Total	384	5,142	95	270	1,372	6,384	1,325	3,935	489	550	389	906	21,241

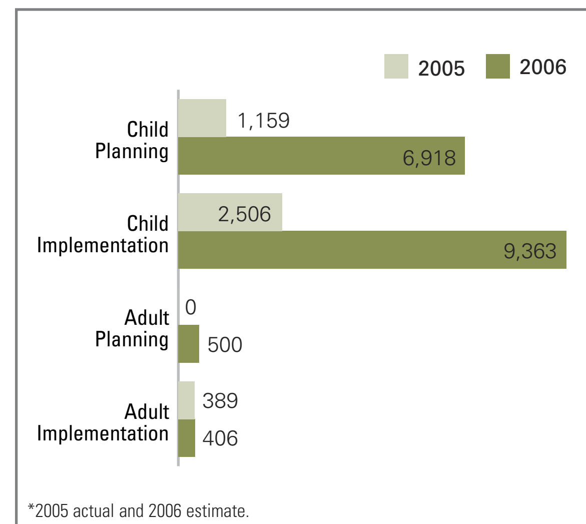
Figure 2 shows that major enrollment gains will occur in the Healthy Kids, Medi-Cal, and Healthy Families programs, similar to the Step by Step first-year results except that fewer children were enrolled in CaliforniaKids in 2005. The estimated increase in total Medi-Cal and Healthy Families enrollment to 13,016 points to the positive impact of a new insurance program on existing insurance programs as well.

Figure 2: Number of Insured by Coverage Program and Year*



Implementation grantees expect to enroll 12,664 people by the end of 2006, including 9,363 children. Planning grantees who will implement their programs in 2006 expect to enroll 6,918 children. All grantees predicted their enrollments of adults would remain the same as in 2005. One grantee, San Francisco, hopes to enroll taxi drivers in 2007.

Figure 3: Number of Insured by Grantee Type and Year*



Coverage Options

Most grantees modeled their Healthy Kids products after the comprehensive Healthy Families benefit package (including vision, dental, and mental health services). Except for the CaliforniaKids programs, which are limited to children ages 2 to 18, all the children's programs cover children from birth to age 18, with family incomes of up to 300 percent of the federal poverty level, including the undocumented.

Adult programs vary more than children's and most, when launched, will not include vision, dental, and mental health services. These plans generally will cover adults from ages 18 to 65 with family incomes of up to 250 or 300 percent of the federal poverty level.

Some grantees have coverage options in 2005 not available in 2004, such as open enrollment in programs such as the Kaiser Permanente Child Health Plan and opportunities to partner with commercial plans.

Six Programs Launched, Others Imminent

Though many grantees experienced operational issues, such as a change in leadership, they were all able to make mid-course corrections and achieve concrete results.

The five planning grantees whose objective was to assess feasibility and develop a coverage approach succeeded and intend to launch their programs in 2006 or 2007. (CHCF funded three 2005 planning grantees — Kings, Mendocino, and Santa Clara — to become implementation grantees in 2006.)

Six of the seven implementation grantees (Del Norte, Fresno, San Luis Obispo, Santa Barbara, Monterey/Santa Cruz, and Sonoma) launched their

Six of the seven implementation grantees (Del Norte, Fresno, San Luis Obispo, Santa Barbara, Monterey/Santa Cruz, and Sonoma) launched their programs in 2005 and one grantee (Tulare) expects to do so in 2006.

Grantees improved key skills important to expanding coverage:

- Designing an insurance product, from identifying a health plan partner to calculating premiums, pricing the product, and developing a provider network.
- Preparing financial analysis and/or model sources and using funding more effectively.

Grantees reported that some tasks required outside assistance: Difficulty in raising funds led some grantees to hire an outside consultant. Grantees often outsourced tasks such as conducting research on a population needs assessment or provider capacity.

Lessons Learned

Flexibility and Perseverance Are Critical to Success

In 2005, grantees confronted challenges similar to those in 2004. Implementation grantees had difficulties managing partnerships, finding adequate financing, and identifying a plan partner. Planning grantees contended with staffing changes and assessing competing options, such as pursuing the California Managed Risk Medical Insurance Board buy-in. Adult-coverage grantees struggled with identifying their target populations and implementation took longer than expected. Non-urban grantees like Del Norte and Sonoma faced limited local government funding. Fund raising was a challenge for nearly all grantees.

Grantees encountered several new issues in 2005:

- Some health plans were concerned about assuming risk for CCS-medically eligible patients with annual family incomes of more than $40,000.
- The Medi-Cal redesign from fee-for-service to a managed care model in some locations was put on hold for 2005, leaving grantees and others uncertain of how to plan for this change.
- Four grantees had delayed approval from the California Department of Managed Health Care for their insurance programs.

Grantees demonstrated flexibility and perseverance in navigating this changing terrain and achieved most of their objectives. Many reported that a combination of in-person technical assistance, high stakeholder commitment, and increased funding for child premium subsidies aided their projects. The statewide 100% Campaign (www.100percentcampaign.org) as well as proposed legislation for statewide coverage for all children provided vehicles for networking and sharing materials and strategies.

The Environment Seems Receptive to Expanded Coverage

Increased private foundation funding coupled with greater organizational capacity provided very favorable conditions for child coverage expansions. For most grantees, this translated into incremental coverage expansions that could serve as a foundation for universal children's coverage should a statewide policy shift provide more funding later on. In the meantime, children's projects are enjoying good relationships among themselves, as well as with local and state agencies.

Although adult projects do not appear to have the same level of support, the problem of uninsured low-income adults is starting to catch the attention of local decision makers. Many counties see adults as the next frontier in coverage expansions, with programs for In-Home Supportive Services (IHSS) workers leading the way.

A Wide Range of Coverage Options Exists

California counties are diverse in the resources they are able to draw on and the political realities they encounter. Step by Step child projects therefore vary with respect to target population, coverage features, plan partners, financing strategy and funding sources, and organizational sponsorship.

Some projects are coalition efforts while others are single organizations with new product lines developed by Medi-Cal managed care plans. Del Norte, Mendocino, and Sonoma Counties are using CaliforniaKids, a primary-care-only coverage program, as an interim product while they seek additional funding for a Healthy Kids product. Others proceeded with a comprehensive Healthy Kids program. Though child projects share the goal of comprehensive coverage for all children, they have different starting points and work toward that goal through different means.

The range of coverage possibilities is even broader with adult populations, especially because counties have to identify populations large enough to attract a plan. Limited funding means counties may have to explore many options.

The two main implications of this diversity for decision makers and funders suggest that:

- A "one size fits all" approach to advancing local coverage efforts may be less effective than a more tailored strategy.
- Insurance and funding gains, while significant at the local level, rarely address the full extent of need even within the local area and fall short of addressing statewide needs. A new infusion of funds and/or mandates from state or federal sources would be necessary to bring universal coverage within reach.

Conclusions

Grantee achievements in 2005 reflect the continued success of Step by Step in facilitating coverage expansions for children and adults under diverse, and often difficult, conditions. Planning grantees successfully positioned themselves to move forward with implementation, and CHCF will fund three of them during 2006. Implementation grantees either have coverage programs in place or will shortly, resulting in significant enrollment gains. Both adult- and child-coverage grantees show promise of creating new models of funding and partnerships.

These gains did not come easily and grantees encountered a variety of operational and external challenges. As in 2004, uncertainty persists around the policy and funding environment, but grantees have demonstrated the commitment and capacity to expand coverage at the local level. Their partnerships with the state and private funders bode well for local coverage expansions in the near future.

PREPARED BY

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Appendix A: Step by Step Grantees, 2005

Planning Grantees

County	Lead Agency	Target Population	Approach / Launch Target	Plan Partner	Stakeholders (in addition to lead agency and plan)	Funding Sources
CHILDREN						
Kings	First 5 Commission	Children ages 0-18, up to 300% FPL	Healthy Kids in 2006	TBD	Children's Health Initiative (CHI): coalition of public and private health care organizations; health and social services agencies; CBOs	Local First 5; Department of Public Health
Marin	County Health Agency	Children ages 2-18, up to 250% FPL	Enhanced CaliforniaKids	CaliforniaKids—a primary care-only coverage program	CHI: Marin First 5 Commission; Health and Human Services; safety-net clinics; Marin Community Foundation	Local First 5; Marin Community Foundation
Mendocino	County Health Agency	Children ages 2-18, up to 250% FPL	Healthy Kids via CaliforniaKids in 2006	CaliforniaKids—a primary care-only coverage program	CHI: First 5 Mendocino; Alliance for Rural Community Health; Dept. of Public Health; providers; schools	HCAP; Medi-Cal Administrative Activities (MAA); Pacific Redwood Medical Group (ER doctors group)
Merced	County Health Agency	Children ages 0-15, up to 300% FPL	Healthy Kids in July 2006	TBD—launching county-organized health system	CHI: Coalition of public and private health care organizations; School districts; health and social services agencies; CBOs	HCAP; First 5 Match; Local First 5; private foundations
ADULTS						
San Francisco	Local health agency and local initiative plan	Taxi drivers	Publicly financed comprehensive coverage in 2007	San Francisco Health Plan (local initiative)	United Taxicab Workers; Board of Supervisors	Special tax
Santa Clara	Local initiative plan	Child care workers	Publicly financed comprehensive coverage in 2006	Santa Clara Family Health Plan (local initiative)	Alameda Alliance for Health; Health Plan of San Mateo; Health Plan of San Joaquin	TBD. Rationalize plan administration and achieve cost savings through regionalization.

Appendix A: Step by Step Grantees, 2005, continued

Implementation Grantees

County	Lead Agency	Target Population	Approach / Launch Target	Plan Partner	Stakeholders (in addition to lead agency and plan)	Funding Sources
CHILDREN						
Del Norte	Community-based organization	Children ages 2-18, up to 250% FPL	CaliforniaKids in December 2005	CaliforniaKids (primary health care plan)	CHI: First 5 Del Norte; health and social services agencies; Office of Education; safety-net clinics; CBOs	First 5; Del Norte Healthcare District; Indian gaming funds; local foundations
Fresno	Community-based organization	Children ages 0-18, up to 300% FPL	Healthy Kids in January 2006	Health Net; Delta Dental; SafeGuard	CHI: Coalition of public and private health care organizations; school districts; faith groups; health and social services agencies; CBOs	HCAP; First 5; private foundations; Kaiser Permanente
San Luis Obispo	Children's Health Initiative	Children ages 0-18, up to 300% FPL	Healthy Kids in September 2005	Santa Barbara Regional Health Authority (COHS)	CHI: Coalition of public and private health care organizations; school nurses; health and social services agencies; community volunteers	First 5 Match; County General Fund Support; Local First 5; private foundations; United Way; local foundations
Santa Barbara	County-organized health system	Children ages 0-18, up to 300% FPL	Healthy Kids in December 2005	Santa Barbara Regional Health Authority (COHS)	Department of Social Services; CBOs; Family Service Agencies	Tobacco Settlement; Local First 5; private foundations; United Way; private donations
Sonoma	Children's Health Initiative and County Health Agency	Children ages 0-18, up to 300% FPL	Healthy Kids (via CaliforniaKids) in January 2006	Partnership HealthPlan of California (COHS); Kaiser Permanente	CHI: Coalition of public and private health care organizations; local governments; health and social services agencies; CBOs	First 5 Match; Local (First 5, United Way); private foundations; hospitals; individual donors/groups
Tulare	First 5 Commission	Children ages 0-18, up to 300% FPL	Healthy Kids in March 2006	Health Net; Delta Dental; VSP	CHI: Coalition of public and private health care organizations; Health Department; County Office of Education; private providers; CBOs	MAA; First 5 Match; AB 495; Local First 5; private foundations; employer contributions; hospitals; individuals
ADULTS						
Monterey/ Santa Cruz	County-organized health system	In-home supportive services (IHSS) workers	Publicly financed comprehensive coverage; Monterey launch in July 2005 and Santa Cruz launch mid 2006	Central Coast Alliance for Health (COHS)	Monterey County Public Authority; Santa Cruz County union	County General Fund Support (Monterey and Santa Cruz)