The Los Angeles Healthy Kids Program Perseveres amid Increasing Financial Strain: Third Case Study of Implementation

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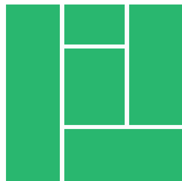

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I. Introduction

Children's health coverage programs in California faced many challenges in 2008 and 2009. With state budget deficits for fiscal year 2010 estimated at $24 billion, proposals to expand children's coverage—so prominent in the recent past—seemed a distant memory. Instead, both Medi-Cal and Healthy Families faced the threat of serious cuts, and even core funding for Healthy Kids programs was challenged when state lawmakers proposed to offset budget shortfalls by redirecting a significant portion of Proposition 10 tobacco tax revenues away from state and local First 5 organizations, and to the state general fund. In the end, most of the cuts were averted. Meanwhile, the Los Angeles Healthy Kids program soldiered on, providing comprehensive health and dental care to roughly 31,000 low-income children (Urban Institute et al. 2009).

Since 2004, the Urban Institute and its partners[1] have conducted a comprehensive evaluation of the Los Angeles Healthy Kids Program, under contract with First 5 LA. This third case study, reporting on the ongoing implementation of Healthy Kids, is presented as part of this five-year evaluation. Researchers from the Urban Institute and the University of California at Los Angeles conducted three days of one- to two-hour interviews with over 15 key informants—including First 5 LA commissioners, local providers, county public health staff, health plan administrators, advocates, and policy analysts—in March 2009. Questions explored new developments related to outreach and enrollment, benefits and service delivery, cost sharing, and financing. Given the approaching end of Healthy Kids Program Evaluation, a final set of questions explored stakeholders' views of the broad "lessons learned" from Healthy Kids and also what these lessons might mean for the future of children's coverage in California. This report summarizes the highlights from these discussions.

II. State Budget Deficits Threaten Children's Coverage Programs

At the time of our site visit, California's budget crisis was prominent on the minds of state and local health officials. With funding for Healthy Kids becoming increasingly scarce, shortages of much larger scale threatened Medi-Cal and Healthy Families. Growing from California's deep budget deficit, 2008 and 2009 witnessed numerous direct threats to the structure and stability of children's coverage programs.

- ***Medi-Cal funding***. In late-2008 and early-2009, the California Department of Health Services enacted a series of cuts to Medi-Cal including, a requirement that children renew eligibility every six months instead of annually. This provision was rescinded, however, when California needed to comply with maintenance of effort rules under the American Recovery and Reinvestment Act of 2009 (ARRA) in order to receive federal "stimulus" funds.

- ***Healthy Families funding***. Healthy Families, in late 2008 was on the verge of closing new enrollment for children because it had insufficient funds to continue open enrollment. First 5 California came to the program's aid, however, by committing $17 million from its reserves to support enrollment for children ages zero through five.

- ***First 5 funding***. Proposition 1D, a bill that would have changed how Proposition 10 tobacco tax revenues are allocated to and administered by First 5 California, First 5 LA, and the 57 other county First 5 commissions, was put before the voters of California in May 2009. Specifically, Prop 1D would have diverted to the state General Fund up to $340 million from First 5 California and reduced funding to county commissions by 50 percent—$268 million—annually for five years. The measure failed, 66 percent to 34 percent, safeguarding core funding for state and local First 5 organizations and, by extension, funds to support health coverage for young children in counties with Healthy Kids programs.

- ***State budget crisis***. California's FY 2010 budget was passed in August 2009 and included $1.4 billion in Medi-Cal cuts and $179 million in cuts to Healthy Families. Cuts in the budget threatened to raise the number of uninsured children in the state to two million (from 915,000), in large part due to the placement of a cap on Healthy Families enrollment and, beginning in October 2009, disenrollment of children from the program at their annual renewal. First 5 California once again acted quickly, this time committing $81.4 million to help Healthy Families forestall disenrollment. A larger solution arrived on September 22, 2009 when Governor Schwarzenegger signed AB 1422 which raised family cost sharing and continued a tax on managed care plans that was scheduled to sunset. Combined with the First 5 California commitment, the law provides funding totaling $196 million to allow nearly 700,000 children to continue receiving coverage under Healthy Families during 2010. The law also removes the enrollment cap that was put in place in July 2009, so that 80,000 children who had been placed on the program's waiting list will be permitted to enroll.

- ***CHI funding***. Support for county Children's Health Initiatives, however, was dealt a blow during the summer 2009 when three of the major philanthropic foundations that have supported premiums for children ages 6 through 18 in county initiatives across the state, each facing their own financial hardship, announced that they would be withdrawing their support from Healthy Kids by the end of 2010.

Combined, these developments put children's coverage in California in a state of limbo, without clear solutions for sustainable funding. Still, in Los Angeles, the Healthy Kids program and partners adjusted to the changing environment and continued fulfilling their mission.

III. Outreach and Enrollment Strategies

Background. First 5 LA contracts with the Los Angeles County Department of Health Services (DHS) to support Healthy Kids outreach, enrollment, retention and utilization (OERU) services. In turn, DHS manages outreach and application assistance subcontracts with a broad and diverse network of 14 community-based agencies, while also maintaining the system's Children's Health Outreach Initiatives (CHOI) database. Relying on a cadre of trusted, multilingual staff, these subcontracted agencies find families with uninsured children, inform them of the availability of coverage, assist parents with completing applications for any available program (including Medi-

Cal, Healthy Families, Healthy Kids and, when it's open, the Kaiser Child Health Plan), assist parents with renewing that coverage, and follow up with families to make sure that their service needs are being met.

Recent years have presented numerous challenges to Healthy Kids specifically, and enrollment entities, generally, including an enrollment cap for children ages 6 through 18 (which has been in place since 2005), cuts to state support for children's outreach and enrollment (most recently, cancellation of funding for Certified Application Assistance in 2008); and increased demands on public coverage programs due to the nation's deep recession. In light of these circumstances, the Healthy Kids program has:

- ***Continued to focus on Medi-Cal and Healthy Families case finding***. As has always been the case, Healthy Kids outreach contractors seek out and assist families with finding health coverage under all available programs. Indeed, since the imposition of the Healthy Kids enrollment cap for children ages 6 through 18, Medi-Cal and Healthy Families applications have constituted a larger and larger share of all the applications submitted by outreach contractors. According to the most recent data available, 61 percent of all applications submitted by outreach contracts were for the Medi-Cal program, 18 percent were for Healthy Families; only 1 percent were for Healthy Kids, and 20 percent were for all other programs (Urban Institute et al. 2009).

  Of note, since the last evaluation site visit, it appears that application processing at California's "Single Point of Entry" (SPE) vendor has considerably improved. Once described as a "black hole" from which it was difficult for outreach workers to obtain information (on, for example, the status of an application), the SPE is now described as working smoothly and efficiently, according to key informant interviewed for this case study.

  Outreach workers interviewed for this case study also described how, over time, they had increasingly used two online tools—the One-e-App and the Health-e-App—to submit applications to the SPE. The One-e-App, which permits application to all of the programs mentioned above, was still described as somewhat unreliable, however. Slow, glitchy operations of the online form, however, were said to be a problem for workers, at times.

- ***Maintained an "interest list" for families with children ages 6–18 seeking coverage.*** As mentioned, Healthy Kids has not reopened enrollment for older children since the program's enrollment cap was imposed in 2005. The program also does not maintain a formal "waiting list" for these children. But OERU workers described how they keep an informal list of parents whom they've encountered who were seeking coverage. This "interest list" has been described as a very valuable tool for workers to use to quickly re-contact parents when new coverage becomes available, as occasionally occurs when the Kaiser Child Health Plan re-opens (discussed below).

- ***Actively referred families with older children to the Kaiser Child Health Plan.*** Kaiser Permanente of California operates its own free-care program for low-income, uninsured children call the Kaiser Child Health Plan. Over several years, this program has opened,

and closed, depending on Kaiser's available resources. During the Healthy Kids enrollment cap, Kaiser has been viewed as a key alternative for families with older kids, and this evaluation's prior reports have found the program to be highly praised and valued by parents, outreach workers, and other stakeholders for its accessible, comprehensive, and high quality care (Hill, Barreto, et al. 2008; Hill et al. 2006; Hill, Palmer, et al. 2008).

Most recently, in August 2008, Kaiser re-opened its Child Health Plan for a period of approximately five months. During the first three weeks after reopening, over 1,600 applications were completed for families with children on OERU workers' "interest lists," affording them quick access to potential coverage. By the end of 2008, nearly 3,700 total applications were submitted to "Other" programs (most, by far, to Kaiser), constituting fully 20 percent of all applications completed by OERU workers during the six months from June through December 2008 (Urban Institute et al. 2009).

According to outreach workers interviewed for this study, Kaiser has been particularly popular among families because it offers coverage for children of all ages. Overwhelmingly, parents appear to prefer enrolling all of their children into the same program, rather than "splitting" them between multiple programs, according to outreach workers. This likely helps explain why enrollment of children ages zero though five under Healthy Kids has steadily declined since the July 2005 imposition of the enrollment cap for children ages 6 through 18, even though enrollment for younger children has remained continuously open. Indeed, some outreach workers believe that parents may disenroll or ignore re-enrollment reminders for their younger children from Healthy Kids when Kaiser opens up, so that they can enroll *all* their kids, young and old, into the same program—Kaiser.

- ***Continued to focus on retention activities.*** Ever since Healthy Kids imposed its enrollment cap on children ages 6 though 18, OERU workers have stepped up their emphasis on retention activities. Workers actively seek out families whose older children are up for renewal (at the 11 month point of their annual coverage period), ask if they've received their renewal packets and whether they need help completing them, and ensure that they understand the critical importance of renewing their children's coverage (else risk losing, and not being able to re-gain, coverage if they allow their older kids' Healthy Kids membership to lapse). Eligibility staff of the L.A. Care Health Plan conduct similar outreach to families with children up for renewal. Combined, these efforts have been extremely effective; Healthy Kids' retention rate is very high, consistently hovering between 85 and 90 percent (Urban Institute et al. 2009; Farias, Cousineau, and E-Nunu 2009). According to public health and health plan officials interviewed for this study, strong rates of retention are also attributed to the "semi-passive" process used by the program, whereby parents are sent renewal forms that are pre-printed with families' personal and income information, and families are asked to simply sign and re-submit the forms if none of the information has changed.

- ***Collaborated with County Social Services to Reach Out to Children on Emergency Medi-Cal.*** While reliable estimates are hard to come by, data from the Los Angeles

Department of Public Social Services suggest that over 74,000 undocumented children in Los Angeles County are enrolled in Emergency Medi-Cal who might also be eligible for, but not enrolled in, Healthy Kids (Hill et al. forthcoming). With the intent of extending more comprehensive coverage than afforded by Emergency Medi-Cal, Healthy Kids officials (including those in the County Department of Health Services that oversee OERU contractors, and L.A. Care officials) have collaborated with county Department of Public Social Services (DPSS) officials to reach out to such children ages zero through five. The first such effort occurred in May 2008, when 4,500 letters were generated and sent by DPSS to parents with children under age 6 enrolled in Emergency Medi-Cal. The letters informed parents of their children's potential eligibility for broader coverage under Healthy Kids and urged them to call a toll-free 1-800 number that connected them to L.A. Care. Officials reported a noticeable spike in applications shortly after this outreach, with several hundred more new applications being filed for young children in June. The increased rate of enrollment was not sustained, however.

During our site visit, we learned that DHS, L.A. Care, and DPSS were planning to institute this type of outreach notification on a routine basis. A Memorandum of Understanding was being developed that would have DPSS identify child enrollees under age 6 each month, send a data file with their contact information to L.A. Care so that a "match" could be run to verify that they were not already enrolled in Healthy Kids, and then send their parents a notice about potential eligibility for Healthy Kids. Under the plan, the letter would include instructions on how to apply for the program—either directly through L.A. Care via a 1-800 number, or by visiting a local enrollment agency. At the time of this writing, the MOU was still under development and local officials hoped that it would be implemented before the end of 2009.

III. Benefits, Service Delivery and Access

Background. The Healthy Kids benefit package is modeled after that offered by Healthy Families—California's CHIP program—and includes a comprehensive range of preventive, primary, acute and specialty services, including dental, vision and behavioral health care. Healthy Kids services are delivered through a managed care network administered by L.A. Care, a not-for profit community health plan with extensive experience serving publicly insured families. Dental services are delivered through Met-Life/Safeguard Dental under a subcontract with L.A. Care. The Healthy Kids delivery system was designed around the existing health care safety net in Los Angeles County (e.g., community clinics, public hospitals, etc.), since it already had experience serving disadvantaged families.

Multiple studies produced under this evaluation have found that the program's benefits and service delivery structure were well-designed, improved access to care among the program's target population, and reduced the burden of uncompensated care on the county's health care safety net. In this evaluation's second case study however, stakeholders reported on a range of challenges that impacted some enrollee's utilization of care, such as: geographic and transportation access barriers, long waits for appointments, improper assignment of primary dental providers, inconsistent use of developmental screening tools by physicians, and delayed

access to mental health care services. During the third case study site visit, key informants shared that many of these challenges have been addressed through modifications to the Healthy Kids service delivery system. Highlights from our discussions are presented below.

- ***Primary care***. The Healthy Kids primary care provider network has largely remained the same. Key informants reported that the county public health safety net, however, has experienced challenges due to a restrictive budget climate; a few clinics and hospitals have closed down in some low-income areas.

- ***Improving service use among Healthy Kids enrollees.*** The Los Angeles County Department of Health Services (DHS) and its outreach contractors have increased their emphasis on the utilization (or "U") component of OERU services. As part of this effort, DHS officials instituted a practice of checking in with newly-enrolled Healthy Kids families four to six months after enrollment into the program to verify that a usual source of care has been selected, and to record any changes in family information.

- ***Behavioral health care.*** L.A. Care added the new subcontractor—PacifiCare (United HealthCare company)—to address a previously identified weak point in the Healthy Kids network: behavioral health. PacifiCare took on the role previously held by the Los Angeles County Department of Mental Health to provide behavioral health services to Healthy Kids enrollees. The new contractor will add nearly 3,000 behavioral health providers to the Healthy Kids network. Informants generally viewed PacifiCare as having potential to improve the delivery of behavioral health services to program enrollees. Still, informants noted that utilization of behavioral health services among Healthy Kids enrollees remained very low.

- ***Dental care***. Safeguard Dental, the Healthy Kids dental service provider, was acquired by MetLife in 2008. Key informants shared that issues identified in earlier evaluation case studies and parent focus groups, such as primary dental provider assignment problems and inappropriate charging of copayments, appear to have been resolved. Some informants from outreach organizations mentioned, however, that while they now hear fewer complaints regarding dental service, some enrollees continued to say they've experienced difficulty finding a dental care provider.

- ***Developmental Services.*** Problems apparently persist with the provision of developmental services care in Healthy Kids, as well as other public coverage programs. Key informants described a significant shortage of developmental care specialists in the Healthy Kids network, but attributed it to systemic, countywide challenges not specific to the program. Other studies completed under this evaluation have noted that the developmental assessments performed by Healthy Kids primary care providers fall short of current American Academy of Pediatrics recommendations for developmental screening and surveillance. However, this lack of screening is not thought to be specific to Healthy Kids providers, but rather reflects practice patterns among pediatric primary care providers nationally. And while no specific trainings on quality developmental screening have occurred for Healthy Kids providers, other efforts directed by First 5 LA have been implemented, such as a new initiative to provide developmental screenings by

phone, and the Early Developmental Screening and Intervention Initiative (EDSI), a clinic-based quality improvement effort to improve developmental screening practices among primary care providers.

- ***Kaiser Child Health Plan.*** As mentioned above, in 2008, outreach workers began to use the Kaiser Child Health Plan as a key referral target for Healthy Kids-eligible families with children ages 6 through 18, affected by program's enrollment hold. In this evaluation's previous case studies, some key informants described challenges related to the Kaiser program—specifically, that enrollment opened and closed depending upon program funding, and that, once enrolled, families were subjected to higher premiums and copayments than those imposed by Healthy Kids. During this case study site visit, however, key informants were more uniform in their praise of Kaiser, for its high quality care and accessible service delivery network. No concerns were expressed that Kaiser's cost sharing levels were creating barriers to enrollment or service use.

- ***Emergency Medi-Cal.*** Limited-scope coverage for the uninsured in L.A. County is also available through the Emergency Medi-Cal program, which is often promoted by outreach workers as "fall-back" coverage for persons not otherwise eligible for federally-funded public health insurance. Various reports developed under this evaluation have discussed how a large proportion of children enrolled in Healthy Kids—perhaps as many as 50 percent—also possess Emergency Medi-Cal coverage (Howell, Dubay, and Palmer 2008). This "dual coverage," many speculate, creates some economic inefficiencies in Healthy Kids, when safety-net providers (for example) bill Emergency Medi-Cal for hospital care that a Healthy Kids enrollee receives, even while L.A. Care receives premiums based on an actuarial equivalent of a comprehensive set of benefits. When speaking with outreach workers during this site visit, we asked whether they ever encourage parents to disenroll their children from Emergency Medi-Cal once Healthy Kids coverage is in place. Interviewed outreach workers uniformly told us "no," that they urged families to retain EMC as a fall-back, in case something were to happen to Healthy Kids.

  We spent considerable time during this site visit discussing efforts by L.A. Care and CHI officials to negotiate a payment arrangement with the state Department of Health Services' Medicaid agency, whereby Healthy Kids would receive a per-child capitation payment roughly equal to the cost of covering acute, emergency services for Healthy Kids enrollees. Receiving such payments would, according to these stakeholders, allow the CHI to stretch its scarce resources and to provide services to enrollees at considerably lower cost. Significant progress on effort was made during 2007, but negotiations broke down when state officials learned that the federal Centers for Medicare and Medicaid Services expressed objections to this arrangement, and hinted that it would not receive federal approval. With the new Obama Administration in place, however, CHI officials were optimistic that new progress could be made on this front. (More detailed analysis of how Healthy Kids and Emergency Medi-Cal work together to serve the children of Los Angeles appears in study developed under this evaluation [Hill et al. forthcoming].)

IV. Cost Sharing

Background. Cost sharing policies under Healthy Families also mirrors those of Healthy Families. A sliding-scale premium structure is employed, exempting families at the lowest income level from paying premiums (at or below 133 percent of FPL), while imposing monthly premiums ranging from $4 to $6 per child per month on families with higher income levels. All families regardless of income, however, are required to pay $5 copayments for certain physician visits, emergency room visits and prescription drugs. Earlier studies for this evaluation documented that the vast majority of families pay no premiums, by virtue of their very low earnings. Focus groups with parents also revealed that while the majority of families feel that Healthy Kids cost sharing is affordable, some (such as those with children with special health care needs) experience financial hardship as a result of paying copayments for multiple physician visits and/or prescription drugs.

During the development of this third case study, we learned that continued tight funding was pressing CHI officials to explore alternative strategies for bolstering financing. During this case study site visit, key informants reported that they were considering such measures as:

- ***Increasing monthly family premiums.*** Key informants stated that, since families have overwhelmingly described cost sharing as "affordable," the program is considering raising premium amounts. Alternatively, program administrators are also considering the possibility of instituting annual enrollment and/or renewal fees.

- ***Increasing Emergency Room Copayments.*** Another strategy being considered by Healthy Kids administrators is increasing the existing Emergency Room copayment from the currently low level of $5 to something higher. Higher copayments would raise program revenue and, more important, help curb families' use of this expensive source of care for routine health needs.

To explore families' willingness and ability to absorb increased cost sharing, L.A. Care officials described that they were developing a survey to be conducted with a representative sample of Healthy Kids families.

Interestingly, most key informants we interviewed were supportive of the idea of increased cost-sharing, though some shared concerns that higher premiums and copayments could create access barriers for some families. Informants believe that families placed a very high value on the coverage made available though Healthy Kids, and thus sense that many would be quite willing to contribute more toward the cost of their children's coverage. Some pointed to the experience of the Healthy Families program during the early years of CHIP implementation. When program administrators learned that many Medi-Cal-eligible children were initially being enrolled in Healthy Families, they began transferring them to the appropriate coverage program. But many families, happy with the new coverage they were receiving under Healthy Families, volunteered to continue paying the program's premiums in order to keep their children enrolled, even after being told that Medi-Cal coverage would be provided at no cost.

V. Lessons Learned from Healthy Kids

In the midst of a deep recession and an unprecedented state budget deficit, stakeholders interviewed for this case study noted the irony that significant reason for optimism for health coverage also existed. For example, at the time of our visit, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) had recently been signed into law providing significantly more stable federal financial support for CHIP programs across the nation. CHIPRA also contained numerous provisions that hold potential for improving states coverage (by allowing expansions of eligibility to 300 percent of poverty), outreach (by promising enhanced funding for states that enact particular strategies for streamlining enrollment and renewal), benefits (by allowing states to provide wrap-around dental coverage to privately insured children whose insurance does not cover dental benefits), and coverage for immigrants (by allowing states to waive the five year waiting period for coverage of immigrant children residing legally in the U.S.). More broadly, by early 2009, President Barack Obama had already identified health care reform as his primary domestic priority and Congress had begun work on a range of sweeping health care reform proposals. Yet the promise of CHIP expansion, in particular, rang hollow given the realization that program enhancements could only be adopted if state matching funds were available, and given California's deficit, the likelihood of that was presently nonexistent.

Still, putting grim fiscal realities aside, key informants shared numerous important and positive lessons learned from nearly six years of experience with the Healthy Kids Program. A synthesis of these lessons as well as thoughts regarding their implications for the future, are summarized below.

- ***Low-income, immigrant families will enroll their children in health coverage, if it is available.*** Prior to the launch of Healthy Kids, there were some who did not believe that low-income immigrant families would sign up for a subsidized health coverage program. Rather, these individuals felt that such families would not see value in health insurance and would continue to rely on the safety net for their care. According to one CHI official, however, the Healthy Kids experience "put the lie to that assumption." Indeed, as this evaluation has documented, the program's enrollment exceeded all expectations when over 45,000 children attained coverage within in the first two years (Urban Institute et al. 2009). Consistent retention rates near 90 percent provide further evidence of the value parents place upon comprehensive, high quality coverage for their children (Farias et al. 2009). And even with an enrollment cap in place since 2005, untold thousands of families with children ineligible for Medi-Cal and Healthy Families have continued to seek coverage under Healthy Kids from OERU agencies.

- ***Outreach and application assistance by trusted community-based agencies and providers really works.*** Many stakeholders believe that much of the credit for Healthy Kids' strong enrollment goes to the community-based agencies and providers that conduct outreach and application assistance throughout Los Angeles County. As reported in this evaluation's previous case study and focus group reports (Urban Institute et al. 2009), these entities are staffed by bilingual members of the community who succeed in developing close, trusted relationships with parents. Of critical import, they also succeed

in putting parents' fears of "public charge" to rest so that they are not intimidated by the prospect of applying for a public health insurance program.

- ***High needs among immigrant children also drive high levels of enrollment.*** Stakeholders also believe, however, that much of families' interest in gaining Healthy Kids coverage is also due to the extremely high and chronic needs of the target population. This evaluation has demonstrated that program enrollees are overwhelmingly poor and high risk, and for the most part never previously possessed coverage. Thus, the creation of a new program directly targeting the needs of children in this group filled a dire need, and was positively received by the families it would help.

- ***Being able to offer coverage for "All Kids" is a powerful message.*** Application assisters, child advocates, and others uniformly believe that outreach is dramatically facilitated when it can offer coverage for "all kids." Indeed, during the first two years of Healthy Kids, having "something for every child" was integral to the outreach message of OERU agencies, and families flocked to the program. During that time, families with children of any age as well as those with "mixed" circumstances—that is, having both citizen and noncitizen children—could be helped through enrollment of their children into Medi-Cal, Healthy Families, or Healthy Kids. In contrast, once funds for new coverage of older children ran out, this outreach message could no longer be consistently expressed and program data clearly show that enrollment rates tumbled. Everyone expected rates for 6 through 18 year-old children would plummet, but they did not fully anticipate the slow, but steady drop that also occurred for younger children ages zero through 5. Over time, as families were less drawn to a program that could cover only some of their kids, total enrollment of younger children dropped from a high of almost 7,900 in 2005 to the present level of just over 5,400 (Sommers et al. 2005; Urban Institute et al. 2009).

- ***Provider "inreach" fuels strong enrollment.*** Another lesson related to outreach is that, in fact, "inreach" is one of the most effective strategies for boosting enrollment. Specifically, health care providers in various communities across Los Angeles consistently generated some of the highest volume of applications for Healthy Kids and the other major health coverage programs. Over time, provider-generated applications typically constituted about one-quarter of all applications (Urban Institute et al. 2009), attesting to the effectiveness of intercepting families when they seek care for their children, checking on their insurance status, and (for the uninsured) enrolling them into coverage on the spot, at the same time they are obtaining care.

- ***Modeling the program after private insurance helps avoid the potential "stigma" of government-sponsored health coverage.*** Some key informants also thought it was critical that Healthy Kids modeled itself after Healthy Families and, in particular, presented itself with the "aura" of private insurance. Families were attracted to the image and "feel" of the program. Meanwhile Medi-Cal, however unfairly, was perceived as the "government" program and one that community "notarios" urged immigrant families to avoid.

- ***Healthy Kids enrollees are low users of health services and, therefore, inexpensive to cover.*** The Healthy Kids Program also taught stakeholders that the target population of low-income immigrant children is pretty inexpensive to cover. Like most children, Healthy Kids enrollees possess relatively good health and did not turn out to be unusually high users of services (Howell et al. 2008; Sommers et al. 2007). Even though Healthy Kids significantly improved the likelihood that children had a usual source of care and used health care services, they still cost less to cover than stakeholders anticipated. In fact, on three separate occasions, L.A. Care renegotiated its premium with the CHI, lowering it because per capita payments were in excess of what the plan needed to cover the costs of Healthy Kids users. The program at its outset paid L.A. Care a monthly premium of $86 per member per month (Hill, Courtot, and Wada 2005). This monthly premium was lowered to $82 in 2005, and then lowered again to $74 per in 2006 (Hill, Barreto, et al. 2008). Program officials seem to have reached an appropriate equilibrium, as the premium has not been lowered again since 2006.

- ***Strong bonds form among organizations with a shared commitment to the target population.*** Stakeholders also observed that the process of creating, implementing, and overseeing Healthy Kids has allowed a broad range of individuals and organizations at the local level to form extremely strong and long-lasting bonds. The groups—including First 5 LA, the California Endowment and various philanthropic foundations, public and private providers, the L.A. Care Health Plan, the Children's Partnership and numerous other children's advocates, the County Department of Health Services, and a host of community-based organizations, among others—shared the common desire to improve access to care for a group of extremely poor and disadvantaged children. Through the Children's Health Initiative coalition, these diverse members deliberated on how best to meet the needs of this population, designed a comprehensive system of care, structured an outreach and enrollment system to recruit enrollees, and oversaw the ongoing implementation of the effort. Throughout this multi-year process, strong bonds were formed which should last well into the future as stakeholders continue to work toward the goal of providing health insurance for *all* children.

- ***Successful coverage of the uninsured can be achieved at the local level***. As a collective, the 24 Children's Health Initiatives across California demonstrated that creative and innovative coverage programs can be initiated and nurtured at the local level. Stakeholders remarked during our interviews about how unique such initiatives are, commenting that no other state can likely boast of similar efforts of such magnitude. Thus, in future years, these individuals thought that CHIs could be pointed to as particularly important examples of local initiatives to cover the uninsured.

- ***Lack of ongoing state-level support of local CHIs leaves the programs in limbo.*** As proud as key informants felt about their accomplishments at the local level, they were equally disappointed that the state government never stepped in to take responsibility for covering Healthy Kids enrollees as they had hoped. The Los Angeles CHI and First 5 LA never viewed philanthropic support as a permanent source of funding for children's coverage. Rather, envisioning a three-year timetable, the goal was to demonstrate that Healthy Kids could effectively meet the needs of vulnerable, uninsured children, and then

use this evidence as a springboard to secure sustainable funding from state (and possibly federal) government sources. But as documented throughout this evaluation, state initiatives to cover all children nearly came to pass in 2005, 2006, and 2007 (Hill and Benatar 2009), but in each case, proposed expansions failed to garner sufficient gubernatorial or voter support. And now that California is facing a deficit of up to $24 billion for fiscal year 2010, the prospects for state support in the immediate future are very unlikely. What's more, as mentioned above, three of the major philanthropic foundations that have supported premiums for Healthy Kids enrollees recently announced their intention to withdraw funding for the programs. Clearly, Healthy Kids programs across California are in limbo.

VI. Implications for the Future

Given the precarious long-term funding prospects for the Los Angeles Healthy Kids program and its siblings across California, many key questions confront policymakers concerned about children's coverage. These include:

- ***What would be lost if Healthy Kids programs had to be shut down?*** At stake are the many key gains that have occurred under the program. As discussed in another of this evaluation's reports, the implications of losing Healthy Kids include:

  - The loss of health insurance coverage for roughly 80,000 children across the state (and over 30,000 children in Los Angeles County, alone);

  - A reversal of all the documented gains in improving children's access to and use of health and dental care;

  - A weakened safety net, which has benefited from the infusion of new resources from Healthy Kids and which has been able to redirect its scarce indigent care dollars to adults;

  - Loss of one of the only remaining sources of outreach funding, most likely leading to lower enrollment of children into both Medi-Cal and Healthy Families;

  - Potentially far reaching effects on children's attendance in school and school performance, as well as impacts on parents productivity in the workforce (if they miss work to take care of their sick children); and

  - A critical loss of momentum on universal children's coverage (Hill and Benatar 2009).

- ***To stretch scarce resources, can Healthy Kids be restructured as a primary care coverage program?*** Given the prospect of decreasing financial support, stakeholders might consider possible alternatives to the current Healthy Kids model. To stretch scarce resources, for example, Healthy Kids could be scaled back to cover primary health and

dental care only, with Emergency Medi-Cal providing "wrap around" coverage for more expensive acute hospital services. Given the likelihood that a large portion of Healthy Kids enrollees already possesses "dual" coverage under both programs, such a transition might not be too disruptive. Another alternative discussed by key informants would be to shift Healthy Kids funds directly to the safety-net, bolstering PPP (Public Private Partnership) indigent care funds to directly support the provision of services to uninsured children and families.

Neither option is very palatable for officials who always envisioned Healthy Kids as a comprehensive coverage program. But dire fiscal realities may force leaders to consider such dramatic changes if services for these children are to continue.

- ***How can California capitalize on new opportunities presented by federal reform?*** Moving forward, a critical question that will confront state and local officials is: How can California capitalize on the federal funding opportunities that are presenting themselves? Once again, the juxtaposition of significant positive changes occurring at the federal level—the incoming Obama administration's push for health care reform, its progressive outlook toward Medicaid and CHIP, and new monies being made available to states through ARRA and CHIPRA—with the most serious economic downturn since the Great Depression and resulting large state budget deficits, places states in a difficult bind lacking the resources needed to draw down federal matching funds. Whether, or to what extent, California will be able to find the resources to take advantage of these opportunities remains to be seen.

Considerable uncertainly now faces Healthy Kids and program officials cannot be blamed for having very mixed feelings about their efforts at this time. On the one hand, stakeholders concerned with improving health coverage for children can take pride in the fact that they helped design and implement a very effective program. The five-year Healthy Kids Program Evaluation, currently winding down, has documented from every conceivable angle that the program succeeded in providing high quality, comprehensive care to children, improving their access to and use of health and dental services, with indications that the health status of participants was also improved. On the other hand, the future prospects for the program are not bright. Repeated reform efforts that would have institutionalized universal children's coverage across California came agonizingly close to fruition, yet failed. And today, funding shortfalls threaten the very existence of Healthy Kids, even as the much larger Medi-Cal and Healthy Families programs struggle to maintain current levels of coverage. Perhaps most sobering, contentious national-level debates make it quite clear that immigrant families and children will not be included in any health care reform plan that may emerge from Congress.

For now, therefore, Healthy Kids perseveres. Without question, the individuals and organizations that have dedicated themselves to this program will continue to serve disadvantaged children and their families until lasting solutions are found.

Note

1. The Urban Institute is working with the University of Southern California, the University of California at Los Angeles, Mathematica Policy Research, Inc., and Castillo & Associates on this evaluation.

References

Farias, A., M. Cousineau, and T. E-Nunu. 2009. "Retention in the Los Angeles Healthy Kids Program." Los Angeles: University of Southern California Center for Community Health Studies.

Hill, Ian T., and S. Benatar. 2009. "What Are the Implications of Closing Healthy Kids?" Washington, DC: The Urban Institute.

Hill, Ian T., T. Barreto, Brigette Courtot, and Eriko Wada. 2008. "Growing Pains for the Los Angeles Healthy Kids Program: Findings from the Second Evaluation Case Study." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/411653_LA_kids_growing_pains.pdf.

Hill, Ian T., Brigette Courtot, and Eriko Wada. 2005. "A Healthy Start for the Los Angeles Healthy Kids Program Findings from the First Evaluation Case Study." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/411259_healthy_kids.pdf.

Hill, Ian T., T. Barreto, Brigette Courtot, Eriko Wada, and E. Castillo. 2006. "What Parents Say about the Los Angeles Healthy Kids Program." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/410308_parents_say.pdf.

Hill, Ian T., L. Palmer, T. Barreto, Eriko Wada, and E. Castillo. 2008. "Parents' Opinions of the Los Angeles Healthy Kids Program Remain High despite Recent Challenges: Findings from the Second Evaluation Focus Groups." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/411796_parents_opinion.pdf.

Hill, Ian T., et al. Forthcoming. "Special Study: Emergency Medi-Cal and Its Connection to Healthy Kids." Washington, DC: The Urban Institute.

Howell, E. M., L. Dubay, and L. Palmer. 2008. "The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/411503_impact_healthy_kids.pdf.

Sommers, A. S., E. M. Howell, and I. T. Hill. 2007. "Utilization in the Los Angeles Healthy Kids Program: A Preliminary Study of Health Plan Administrative Data." Washington, DC: The Urban Institute. http://www.urban.org/publications/411517.html.

Sommers, Anna, Joshua McFeeters, Ian Hill, Eriko Wada, Michael Cousineau, Erin Cox, Moira Inkelas, Patricia Barreto, and Tom Rice. 2005. "Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: Second Quarter, 2005." Washington, DC, and Los Angeles: The Urban Institute, the University of Southern California, and the University of California at Los Angeles.

Urban Institute, the University of Southern California, and the University of California at Los Angeles. 2009. "Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: Third and Fourth Quarters, 2008." Washington, DC, and Los Angeles: The Urban Institute, the University of Southern California, and the University of California at Los Angeles.