GRANTWATCH REPORT

Lessons From The Field: Expanding Health Insurance Coverage One County At A Time

Important short-term gains can be realized from investing in local capacity to expand insurance coverage.

by Annette L. Gardner and Patricia H. Mintz

ABSTRACT: From 2004 to 2007 the California HealthCare Foundation's Step by Step: Local Coverage Expansion initiative supported insurance coverage expansions for uninsured children and adults in thirty California counties. In this paper we describe the initiative and its achievements as well as challenges for grantees. Also, we discuss the implications of the initiative's outcomes for expanding coverage locally and more broadly. Implementing new insurance programs is possible in the most difficult settings. Although there are real challenges to sustaining these expansions and limits to what they can accomplish in the face of major unmet needs, they may lay useful groundwork for broader expansions later. [*Health Affairs* 27, no. 5 (2008): 1454–1460; 10.1377/hlthaff.27.5.1454]

THERE HAS BEEN much activity in many U.S. communities to expand coverage to uninsured populations. These initiatives range from efforts to better coordinate health care delivery systems to launching new insurance programs for people who are ineligible for existing public programs. Evaluations of these community-level expansions have increased our understanding of local capacity to expand coverage for the uninsured. For example, Erin Fries Taylor and colleagues described numerous barriers to what localities could do, including the limited capacity to fund and sustain a program that meets the needs of the entire community.[1] However, community-based programs may be essential for pilot-testing new strategies, and they provide a "reality check" that can inform development of programs for broader application.[2] In this paper we describe outcomes of the Step by Step: Local Coverage Expansion Initiative, a multicounty effort to accelerate the launch of local insurance programs in California, and we discuss what can be achieved by localities in the face of large financial and political constraints.

Background

In 2004 the California HealthCare Foundation (CHCF) launched the Step by Step initiative. The initiative was driven in part by the ability of a growing number of local programs (particularly those targeting children ineligible for existing public insurance programs) to secure funds for coverage expansions. In California there were 316,000 uninsured children who were not eligible for public programs in 2005.[3] Of these, 136,000 were undocumented.[4] For example, by 2003 four California counties

Annette Gardner (annette.gardner@ucsf.edu) is an academic specialist at the Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco (UCSF). Patricia Mintz is an independent consultant who served as project director for the Step by Step: Local Coverage Expansion Initiative.

DOI 10.1377/hlthaff.27.5.1454

had launched comprehensive Healthy Kids insurance programs targeting uninsured children.[5] Twenty-four counties were then in the early stages of planning to launch similar programs using tobacco settlement, tobacco tax, and county funds, augmented by philanthropic support.

Despite a state budget shortfall in 2004, this period was characterized by high interest in children's coverage expansions among communities and private philanthropies. The CHCF was one of four statewide foundations to provide premium subsidies or support for technical assistance, or both, to California communities to expand insurance coverage. Other funders included the California Endowment, Blue Shield of California Foundation, and the David and Lucile Packard Foundation. Many Step by Step grantees received funding from one or more of these other sources.

From 2004 to 2007 Step by Step awarded forty-eight grants totaling $3.7 million in thirty counties. Several types of organizations—local government agencies, local Medi-Cal (California Medicaid) managed care plans, and community-based organizations—were funded to plan or implement coverage expansions.[6] These grants were intended to facilitate access to external consultants who had expertise in developing insurance products for low-income populations.[7] Two types of one-year technical assistance grants were available. Small planning grants (up to $50,000) helped coalitions or agencies define needs in the target population, identify options, and, if appropriate, develop an implementation plan. Larger implementation grants (up to $200,000) helped coalitions or agencies develop and execute a successful strategy to launch an insurance product. In 2007 the CHCF provided nine stabilization grants to previously funded child-focused grantees to conduct contingency planning under various state and federal policy scenarios. Many Step by Step projects received multiple years of funding. In all, twenty-five coalitions or agencies received funding to expand insurance coverage (fifteen child-focused grantees and ten adult-focused grantees) (Exhibit 1).

The goals of the initiative were to (1) foster development and implementation of local coverage programs that would otherwise not be implemented; (2) encourage efforts to improve and streamline enrollment in local and state coverage programs and thereby maximize use of local resources; and (3) increase the number of insured Californians.

To achieve these goals, Step by Step was intentionally broad in its reach. It assisted counties that might otherwise not consider insurance coverage expansions because of limited financial resources or limited availability of technical assistance. For example, in rural counties where comprehensive public health plans do not operate, CaliforniaKids (Cal-Kids), a primary care–only coverage program, was more feasible than the comprehensive Healthy Kids product.[8] Also, Step by Step supported the planning and implementation of insurance expansions through a tailored approach that emphasized local strengths and resources. Finally, low-income working adults were included in the initiative because of their limited access to affordable health care and insurance and to gain insights on their distinct needs. Specific groups for whom there were potential funding mechanisms were selected, including child care workers, farm workers, In-Home Supportive Services (IHSS) workers, taxi drivers, and low-income working adults in general. In 2006 the CHCF conducted an environmental scan that indicated few opportunities remained to leverage public and private funding streams to pay for new local health insurance programs. Consequently, the final year of funding for Step by Step was 2007.[9]

Step By Step Accomplishments

The CHCF conducted annual evaluations to monitor grantee progress and an endpoint evaluation to assess achievement of initiative goals, as well as challenges encountered by grantees. Some achievements, such as increased enrollment in new and existing insurance programs, cannot be totally attributed to Step by Step, because many grantees received funding from other sources. Nevertheless, Step

EXHIBIT 1
Insurance Products Launched In California, By County, 2004–2008

County or region	Grant type	Target population[a]	Insurance product
Child-focused grantees (15 grantees, 18 counties)			
Del Norte County	Planning, implementation	Children ages 2–18 up to 250% of poverty	Launched CalKids in August 2005
Fresno County	Planning, implementation, stabilization	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in January 2006
Humboldt County	Planning, stabilization	Children ages 2–18 up to 250% of poverty	Launched CalKids in August 2006
Kings County	Planning, implementation	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in July 2007
Mendocino County	Planning, implementation, stabilization	Children ages 2–18 up to 250% of poverty	Launched CalKids in May 2006
Merced County	Planning, stabilization	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in January 2007
Napa County	Planning	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in November 2005
Orange County	Planning (2), implementation, stabilization	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in October 2006
Placer County	Planning	Children ages 0–6 up to 300% of poverty	Launched as part of Healthy Kids Healthy Futures in 2008
San Luis Obispo County	Planning, implementation, stabilization	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in September 2005
Santa Barbara County	Implementation	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in December 2005
Santa Cruz County	Implementation	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in July 2004
Sonoma County	Planning, implementation, stabilization	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in January 2006
Tulare County	Planning, implementation	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in March 2006
Multicounty: Healthy Kids Healthy Futures (Sacramento, Colusa, Yuba, and El Dorado Counties)	Implementation, stabilization	Children ages 0–18 up to 300% of poverty	Launched Healthy Kids in September 2006
Adult-focused grantees (10 grantees, 15 counties)			
Fresno County	Planning, implementation	Farm workers	Did not proceed
Los Angeles County	Planning (2), implementation	Child care workers	Did not proceed
San Francisco (City and County)	Planning	Taxi drivers	Did not proceed
San Mateo County	Planning	Adults under 400% of poverty	Launched services expansion in 2007
Santa Barbara County	Implementation	IHSS workers	Launched IHSS coverage in 2005
Santa Clara County	Planning (2), implementation	Low-income worker adults under 350% of poverty	Scheduled to launch in late 2008
Santa Cruz and Monterey Counties	Implementation	IHSS workers	Launched in Monterey in 2005 but not in Santa Cruz

EXHIBIT 1
Insurance Products Launched In California, By County, 2004–2008 (cont.)

County or region	Grant type	Target population[a]	Insurance product
Multicounty: Kings, Sutter, Tulare, Nevada, Plumas, San Benito, and Sierra Counties	Implementation	IHSS workers	Launched in 2006 and 2007 in 7 counties
Statewide: California Hispanic Health Care Association	Planning	Farm workers	Did not proceed
Statewide: University of California, Berkeley	Planning	Low-wage Medi-Cal respite workers	Did not proceed

SOURCE: Step by Step grantee evaluation reports and interviews.
NOTES: Three counties (Orange, Los Angeles, and Santa Clara) each received two planning grants. Marin County, one of the forty-eight grantees, received a planning grant to do a benefit analysis; Marin is not included in this exhibit. One stabilization grant was awarded to a six-county project, but it is not included in this exhibit because it had not previously received a planning or implementation grant. IHSS is In-Home Supportive Services.
[a]All products listed here, except those targeting IHSS workers and low-wage Medi-Cal respite workers, included the undocumented.

by Step played an important role in laying the groundwork for these gains via its planning grants. It also contributed to project gains in important ways later on, such as strengthening systems to track grantee enrollment. The following is a summary of grantees' accomplishments.

■ **Implementation of new local coverage programs.** All child-focused grantees (fifteen grantees in eighteen counties) launched an insurance product by early 2008 (Exhibit 1). Twelve grantees launched Healthy Kids programs, and three launched CalKids products.

Seven of the ten adult-focused grantees developed a health insurance plan. Of these, three implemented IHSS coverage in nine counties, and one plans to implement an insurance product for low-income workers in Santa Clara County later in 2008. Three grantees developed plans but encountered financial barriers that did not allow for implementation in Fresno and Los Angeles Counties and in the city and county of San Francisco. One grantee considered an insurance plan but instead selected a non–insurance coverage program to cover lower-income adults in San Mateo County. The two statewide planning grantees were unable to craft a feasible coverage plan because of other barriers, such as partnership issues.

■ **Increased enrollment in new and existing programs.** Nearly all child-focused grantees used Step by Step resources to expand their outreach, enrollment, retention, and utilization (OERU) activities; they enrolled children in existing and new insurance programs, including Medi-Cal, Healthy Families (the State Children's Health Insurance Program, or SCHIP), Healthy Kids, CalKids, and the Kaiser Permanente Child Health Plan. Most enrollment strategies are community-wide and include partnerships among numerous agencies. Many grantees have Certified Application Assister (CAA) networks, with some grantees hiring OERU case managers. Some counties use a combination of strategies, such as One-e-App, a telephone help-line, and a multiagency coalition. Strategies varied because of counties' differing capabilities and structures. For example, some focused on electronic enrollment, others on training existing community health workers in enrollment, and others on hiring people specifically to work on outreach and enrollment.

Step by Step child-focused grantees had enrolled some 91,083 children (new enrollees) in all of the children's health insurance programs as of 2008: Healthy Families (39,375), Medi-Cal (22,903), Healthy Kids (15,698), Kaiser Permanente Child Health Plan (10,490), and CalKids (2,617). Additionally, approximately

46,800 children were reenrolled in new and existing insurance programs during 2004–2008.

There were comparatively modest gains in adult-focused programs. Some 5,152 adults were anticipated to be enrolled in insurance programs by December 2008. Most of these gains were IHSS workers (4,100); coverage for them is financed predominantly by state and federal Medi-Cal funding, with modest local contributions. Most other adult worker programs under Step by Step lacked an existing funding source that could be leveraged.

■ **Increased funding from diverse sources.** Although identifying and securing funding was cited as one of the most challenging aspects of their projects, nearly all child-focused grantees developed the infrastructure—for example, by hiring a grant writer—to secure funding. Grantees were diverse in their approaches: some of them emphasized private funding, while others focused on state funding, particularly OERU funding. Grantees secured a total of $51 million during 2004–2007. The major funders varied somewhat by year. Private foundations' contributions steadily increased through 2007, while public First 5 funding (California Proposition 10 [tobacco tax] funding) peaked in 2005.[10]

■ **Increased access to and quality of care.** For many Step by Step grantees, it is too early to assess whether enrollees are using health care services appropriately. Most grantees are collecting data from their health plan partners and are establishing a baseline for comparison later on. However, the findings from external evaluations of three mature Healthy Kids programs (Santa Clara, Los Angeles, and San Mateo Counties), which were not funded under Step by Step, indicate that these programs are linking children to services and contributing to increased access to and use of health care and dental services.[11] Also, researchers from the University of Southern California have demonstrated the positive effects of Healthy Kids programs on rates of preventable hospitalizations.[12]

Lessons And Challenges

In this section we highlight the practical lessons learned for increasing capacity to launch insurance programs at the local level, as well as the challenges that should be considered when groups propose and when funders support these efforts.

■ **Augmenting local capacity.** In practical terms, Step by Step resources supplemented grantees' existing expertise in specific areas. Particularly useful resources included consultants who tackled the complex issues of insurance product development and creation of a provider network; hands-on project management support that provided additional technical assistance; and facilitated grantee networking and sharing of best practices, such as monthly peer-group conference calls and annual meetings. These activities helped form effective working partnerships among grantees. For example, six Central Valley counties worked together to develop common administrative guidelines with their health insurance plan, HealthNet, to achieve savings. Many of these aspects of the Step by Step initiative could be readily replicated and applied to other efforts to expand coverage.

■ **A flexible model that accounts for local diversity.** Step by Step was flexible and allowed grantees to adapt resources to their specific needs. Consequently, grantees—particularly those in counties that do not have a Medi-Cal managed care plan and in rural counties with small target populations—were very creative in marshalling their resources and mobilizing stakeholders. Also, the three types of grants (planning, implementation, and stabilization grants) provided a high level of customization and were an opportunity to influence local decisions and processes early on.

■ **Practical and political challenges to be considered.** Step by Step child-focused grantees faced real challenges at the local level from 2004 to 2007. Some faced major obstacles in building provider networks in locales where providers did not want to take part in an organized network with a fixed fee schedule that

yielded less than their customary fees. Also, grantees in rural areas found it difficult to attract and retain physicians. Grantees reported that some partnerships were more elusive than others; it was particularly difficult to find a health plan partner in counties without a Medi-Cal managed care plan. Some grantees with small target populations found it difficult to attract commercial plans. Nevertheless, all the child-focused grantees identified a commercial plan, CalKids, or Medi-Cal managed care plan as a partner.

Supporting diverse grantee projects poses some challenges as well. A strategy of supporting local solutions to address local needs allowed resources to be distributed widely but also resulted in projects that varied as to risk. Pursuing such a strategy suggests the need for a candid assessment of project goals at the outset and a willingness to tolerate some uncertainty with respect to outcomes.

"Ongoing financial sustainability remains an enormous challenge for most of the child-focused programs."

Ongoing financial sustainability remains an enormous challenge for most of the child-focused programs. The enrollment caps for children ages 6–18 in some counties and cutbacks in OERU funding in 2007 have slowed—and in some cases halted—enrollment growth. Funding secured by grantees may only go so far in sustaining these programs.

Adult-focused grantees' greatest challenges were securing funding and garnering stakeholder support at a time when adult insurance coverage is decreasing nationally. Some grantees' projects came very close to launching an insurance product. However, identifying funding for even a relatively modest benefit package was extremely difficult. The monthly premium for adult coverage ($150–$300) was much higher than the premium for a child ($70–$100).

Although child-focused grantees enjoyed high visibility and support during 2004–2006, the uncertain state and federal policy environments during this time complicated Step by Step grantees' planning activities and threatened program sustainability. A statewide effort that included many Step by Step grantees, as well as advocates supportive of expanded insurance coverage for children, encountered a series of setbacks to its state-level policy initiatives. In 2005 Gov. Arnold Schwarzenegger (R) vetoed legislation (AB 1199) that would have created the California Healthy Kids Fund. In 2006 Californians narrowly defeated Proposition 86, an increase in the cigarette tax by $2.60 per pack, which would have included funding for children's coverage expansions. In 2007 the governor eliminated funding to increase outreach and enrollment activities. Finally, the recent failure to enact health care reform in California (ABX 1-1) and the projected $17.2 billion state budget deficit suggest that state support for fiscal year 2009 for children's insurance expansions in the near future is unlikely. Scaled-back proposals to expand coverage for children are being considered. Proposals include SB 32, a measure to provide coverage for all children with family incomes at or below 300 percent of povery.

At the federal level, the extension of a scaled-back version of SCHIP, which will cover children up to 200 percent of poverty, will likely increase the burden on local child-focused programs in California, because many Healthy Kids programs enroll children up to 300 percent of poverty.

Conclusion

The lessons from the Step by Step initiative indicate that important short-term gains can be realized from investing in local capacity to expand insurance coverage, such as strengthened coalitions and increased leadership support for expansions. Also, many grantees' success in forming partnerships with insurance plans and mustering sizable amounts of resources to fund these expansions is noteworthy. These capacity gains could be useful if health care reform gains traction at the state or federal level: The infrastructure is in place in

several California counties to enroll and retain children and adults in insurance programs of various types.

Although Step by Step grantees demonstrated great flexibility and perseverance in navigating a changing terrain and were successful in planning or launching their projects, or both, their gains are at risk of being eroded by diminishing prospects for insurance coverage expansions at the state level. In addition, these insurance coverage and funding gains are unlikely to address all of the needs within the local area or statewide. Unfortunately, state-level solutions that could address these needs have been slow in coming. The long-term sustainability of these coverage programs hinges on the collective efforts of grantees and advocates to convince California policymakers and the public that these gains are worth preserving.

The authors thank Marian Mulkey, senior program officer at the California HealthCare Foundation (CHCF), for her assistance in reviewing this paper. The evaluation and paper were supported by a grant from the CHCF.

NOTES

1. E.F. Taylor, P. Cunningham, and K. McKenzie, "Community Approaches to Providing Care for the Uninsured," *Health Affairs* 25 (2006): w173–w182 (published online 11 April 2006; 10.1377/hlthaff.25.w173).
2. D.I. Chang, "Applying Lessons Learned in Communities to Programs and Policies at the Federal Level," *Health Affairs* 25 (2006): w192–w194 (published online 11 April 2006; 10.1377/hlthaff.25.w192).
3. S.A. Lavarreda et al., "More than Half of California's Uninsured Children Eligible for Public Programs but Not Enrolled," October 2006, http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=193 (accessed 28 May 2008).
4. E.R. Brown, N. Pourat, and S.P. Wallace, "Undocumented Residents Make Up Small Share of California's Uninsured Population," March 2007, http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubid=222 (accessed 28 May 2008).
5. Healthy Kids programs mirror the Healthy Families program, California's State Children's Health Insurance Program (SCHIP). They provide comprehensive coverage to uninsured children, including the undocumented, up to 300 percent of the federal poverty level. They are typically funded through a combination of public and private sources.
6. Medi-Cal (California's Medicaid program) has two systems: fee-for-service Medi-Cal, in which providers bill the state directly, and managed care. Under managed care, counties may choose one of three models: County Organized Health System, a county-run plan that enrolls the county's entire Medi-Cal population; Two-Plan model, in which Medi-Cal recipients can choose between a quasi-public plan and a commercial plan (a health maintenance organization, or HMO); and Geographic Managed Care, in which the state contracts directly with multiple private insurance plans.
7. Six grantees were funded under Step by Step to assess the feasibility of launching One-e-App, an electronic enrollment program, in their counties. These grantees are not included in the total number of grantees or total amount of funding. The California HealthCare Foundation and California Endowment funded development of One-e-App.
8. CaliforniaKids is an independent nonprofit organization that provides premium-subsidized, comprehensive preventive and primary health care services to children ages 2–18. The program is subsidized by corporations, foundations, and individuals.
9. See California HealthCare Foundation, "Step by Step: Local Coverage Expansion Initiative—Concluding Summary," February 2007, http://www.chcf.org/documents/insurance/StepByStepConcludingSummary.pdf (accessed 24 June 2008).
10. First 5 funding has focused on subsidizing children ages 0–5, while the California Endowment and Blue Shield of California Foundation offered premium-subsidy coverage focused on children ages 6–18 who are enrolled in Healthy Kids.
11. C. Trenholm et al., "Three Independent Evaluations of Healthy Kids Programs Find Dramatic Gains in Well-Being of Children and Families," In Brief, no. 1, 19 November 2007, http://www.urban.org/publications/411572.html (accessed 3 March 2008).
12. M.R. Cousineau, G.D. Stevens, and T.A. Pickering, "Children's Health Initiatives Have Helped Prevent over 1,000 Unnecessary Child Hospitalizations Annually" (Los Angeles: University of Southern California, December 2007).