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Will Healthy Kids Increase Access for Yolo County Children?

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"Greater than the tread of mighty armies is an idea whose time has come."

Victor Hugo

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Abstract

There are approximately 51,000 children between the ages of birth to age 18 years that reside in Yolo County. It is estimated that approximately 28,000 live in homes where the family's combined annual income is at or below 300% of the Federal Poverty Line (FPL). Of that, approximately 3,605 are uninsured and may be eligible for existing public health programs. It is also estimated that 2,400 (66%) of the uninsured qualify for existing public health programs and that 1,200 (33%) do not qualify due to other factors such as immigration or income that exceeds current eligibility requirements.

Through the leadership of Yolo County Children and Families Commission, a local children's health coalition composed of over 30 public and private business leaders was created with its primary mission to create access to quality healthcare for Yolo County children. After examining many different models to improve access to healthcare, the coalition choose Healthy Kids insurance program. Healthy Kids was initially created through a similar coalition in Santa Clara County. Whereby, an insurance product was created to cover children who did not qualify for existing public health programs but were low-income and uninsured. This paper examines whether offering a Healthy Kids insurance product to parents in Yolo County will be perceived by parents to increase access to healthcare for children in Yolo County.

Primary data was collected through a questionnaire in which parents of children birth to age 18, that are currently uninsured, are at or below 300% of the FPL, and who do not qualify for existing public health programs where asked a series of questions pertaining to the correlation between being enrolled in a Healthy Kids insurance program and

improved access to healthcare. Overwhelmingly, over eighty percent of parents perceived that Healthy Kids insurance product would improve their children's access to healthcare services in Yolo County.

Introduction

Traditionally two basic strategies have been used to increase access to care for the uninsured; 1) increase the number of people with insurance, or 2) increase access and availability to low cost or free services to those who are uninsured. Often this has been done through community health centers.

Yolo County is one of five managed care County Organized Health Systems (COHS) in California with a local health plan administering the MediCal program. It is proven that communities who have a higher level of insured individuals and a strong community health center capacity have the best access. It is also proven that the insured are in overall better health than the uninsured. This being said, insurance coverage alone has greater gains than community health centers. (Expanding Care versus Expanding Coverage: How to Improve Access to Care, 2004) Yolo County is fortunate to have many of the important elements that ensure access. It has a strong county organized health system, community health centers and hospitals systems that all work collaboratively to improve health outcomes for Yolo County residents. However, there remain over 1,200 low-income children that are uninsured and are at risk.

In 2002, Yolo County Children and Families Commission (YCCFC) coordinated a community needs assessment whereby 11 focus groups were held with parents and families throughout the county to identify community needs. In all of the 11 focus groups held, parents identified access to healthcare as a major need for their children. YCCFC is aware that barriers to healthcare can hinder a child's ability to be healthy and ready to

learn. Having access to a regular primary care doctor and following the recommended periodicity for pediatric care is critical to ensure that conditions are diagnosed and treated in a timely manner. That being acknowledged, YCCFC updated its Strategic Plan and identified the Access to Quality Healthcare Initiative as one of its funding priority areas over the next five years. The Commission has committed $2.5 million to address this priority over a five-year period.

From 2002, until mid 2004, YCCFC considered different strategies to improve access. However the two main interventions mentioned previously were chosen to be examined extensively: 1) insurance coverage and 2) expanding low cost health care services throughout community health centers. YCCFC concluded that offering low cost insurance coverage would assist both the populations that currently use community health centers for care and those who delay care until the condition worsens and either use emergency rooms or pay higher prices for private care. It would assist the community health centers by enabling them to receive reimbursement for uncompensated care, which may ultimately lead to increased revenue and the expansion of direct services. Children are fairly inexpensive to cover for comprehensive insurance, approximately $100 per child per month.

In mid 2004, YCCFC began to explore what other county commissions/coalitions had done to improve access to care. The most developed model was the Santa Clara Children's Health Initiative (SCCHI). SCCHI was the first county coalition in California to create a county wide Healthy Families look-a-like health insurance product for children. SCCHI's Healthy Kids product was launched in January of 2001. The concept was simple;

provide comprehensive health insurance for every child in Santa Clara County that lived below 300% of the FPL. They concurrently launched an outreach and enrollment plan with a message to families that SCCHI will find coverage for each child regardless of immigration status. SCCHI has not only seen steady enrollment in the new Healthy Kids product, but its enrollment campaign has promoted increases in enrollment in public programs such as Healthy Families and MediCal because no child gets left behind.

Like Santa Clara County, Yolo County families have children with mixed immigration status. For example, it is not uncommon to have one child that is a documented citizen and another who is not. Further research may prove that many families do not enroll their eligible children because it does not make sense to them that their other children go without. SCCHI Model allows families to work with one application assistor to help them maneuver through the maze of applications and ensure that all children will receive insurance. Since SCCHI inception, nine other counties have created Healthy Kids Programs; Los Angeles, Riverside, Kern, San Francisco, San Mateo, San Bernardino, San Joaquin, Santa Cruz and San Luis Obispo. Yolo County will be the first rural county to implement a Healthy Kids program.

In Yolo County, there are approximately 51,000 children between the ages of birth to age 18 years. It is estimated that approximately 28,000 live in homes where the family's combined annual income is at or below 300% of the Federal Poverty Line (FPL). Of that, approximately 3,605 are uninsured and may be eligible for existing public health programs. It is also estimated that 2,400 (66%) of the uninsured qualify for existing public health programs and that 1,200 (33%) do not qualify due to other factors such as

immigration or income that exceeds current eligibility requirements. It is believed that for these 1,200 children the lack of insurance is a barrier to receive the care they need.

Therefore a study was conducted with families of children birth to age 18 that are currently uninsured, are at or below 300% of the FPL and who do not qualify for existing public health programs to examine whether there is a perceived benefit that access be improved with enrollment in a Healthy Kids insurance product. Primary data was collected through in person interviews to determine the perceived benefit of healthcare on access issues such as the establishment of a medical home, decrease wait times to access services and not delaying care when needed. These findings could encourage other small rural counties to create child health programs.

Background

Overview of Public and Private Health Programs Offered in Yolo County

MediCal -Administrative Overview

MediCal is a state and federally funded (50/50 match) program that provides health care coverage for low-income people who lack health insurance. The United States Department of Health and Human Services, Center for Medicare and Medicaid (MediCal) provides regulatory oversight such as waivers and state plans. The California Health and Human Services Agency Medical Care Services Division, directly administers MediCal. MediCal contracts with EDS, which is the Medi-Cal fiscal agent, and other vendors for dental care, managed care outreach and enrollment and data collection and management.

In Yolo County, the Department of Employment and Social Services (DESS) conducts eligibility determination, enrollment and recertification. There are different

administrative Medi-Cal models such as fee for service or managed care arrangements. Yolo County is a managed care County Organized Health System (COHS).

Overview of Medi-Cal Managed Care-County Organized Health System

In 2001, the Yolo County Board of Supervisors passed a county ordinance to adopt the Solano, Napa, Yolo Commission on Medical Care, dba, Partnership Health Plan to operate its Medi-Cal program as a County Organized Health System (COHS). To date, there are only five COHSs in California. In this Medi-Cal managed care model, enrollment in a single county run plan is mandatory for the Medi-Cal population and occurs concurrently with enrollment in the Medi-Cal program. This is a model that provides a county specific managed care delivery model.

COHSs are required to be independent public entities that meet Knox-Keene licensing requirements (state requirement for licensure of HMO's) but do not necessarily have to be Knox-Keene licensed. Except for Partnership Health Plan all other COHSs are Knox-Keene licensed. Partnership Health Plan negotiates its contract rates through the California Medical Assistance Commission (CMAC) who serves as the mediator between Partnership and the Department of Health Services and are paid a per member each month rate, which is known as a capitated rate. Partnership then contracts with the two hospital systems and private doctors on either a fee for service or capitated basis. The majority of services mirror the services offered under the fee-for-service Medi-Cal model; however, under a COHS special arrangements can be made to include certain services that may not be ordinarily covered. This gives the county more flexibility to tailor the scope of benefits to the needs of the county it serves.

Yolo County Medi-Cal Data

- As of Jan. 2003 total Medi-Cal enrollment was 26,125 (increasing 1-2% per year since 2001)
- 21,800 enrolled in Partnership Health Plan-Managed Care
- Approximately 3900 are 0-5
- 55% are on Public Assistance
- 36% are medically needy

State Medi-Cal Data

- Provides health coverage for 55 percent of California's children with family incomes below 100 percent of FPL
- Pays for 42 percent of all births in the state.
- Covers the majority of persons living with AIDS.
- Medi-Cal acts as a vital safety net for children

SCHIP-Healthy Families

In 1997 Congress passed the State Children's Health Insurance Program (SCHIP). Individual states were given the option to use the funds to:

- Expand Medicaid (Medi-Cal)
- Create or expand a children's health program or
- Combination of the two

California chose to create the Healthy Families program, which was designed to offer comprehensive health insurance to children whose income levels were too high to receive Medi-Cal. Currently, Healthy Families covers children up to 250% of the poverty rate.

Differences between Healthy Families (HF) and Medi-Cal (MC)

- Medi-Cal has a broader scope of benefits with the use of Early Preventative Screening Diagnosis and Treatment (EPSDT) funds
- Federal government reimburses 65% of HF expenditures versus 50% of MC
- HF enrollees pay monthly premiums and co pays.
- HF is delivered under a managed care plan administered by Managed Risk Medical Insurance Board

Yolo Healthy Families Data

- Current enrollment for Yolo County is 2,497.
- In FY 0/04 Yolo County had 1,250 new enrollees.
- 44% of Yolo County Healthy Families children reside in Woodland.
- There are 589 children enrolled in W. Sacramento, 319 in Davis, 231 in Winters.

- Unfortunately 70% of families were disenrolled last year of that figure approximately 48% were due to lack of payment.

Children's Health Disability Prevention Program /Gateway (CHDP)

Administered by the County through the Children Medical Services Branch (CDHS)of the California Department of Health Services. The CHDP program is a preventive health program serving California's children and youth. Through the CHDP program, eligible children and youth receive periodic preventive health assessments. Children and youth with suspected problems are then referred for diagnosis and treatment. CHDP works with a wide range of health care providers and organizations in Yolo County which include private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, social and community service agencies. CHDP is used as a "Gateway" to provide access for approximately 20, 0000 (Medi-Cal plus Gateway exams for FY03/04 estimates) children in Yolo County to the Medi-Cal or Healthy Families Program through an automated pre-enrollment process. A single application event will determine eligibility for temporary enrollment into Medi-Cal or Healthy Families. Pre-enrollment provides immediate temporary full-scope comprehensive health care coverage to qualifying children for 60 days while eligibility is determined. If eligibility is denied the children will still remain on Medi-Cal or HF for 60 days and depending on the reasons for denial will either be placed on restricted and/or emergency Medi-Cal.

Yolo County CHDP Data FY 02/03:

Total Number of CHDP visits were 14,410

- 589 Medi-Cal/Headstart
- 4,349 Non-Medi-Cal (State only reimbursed)
- 9,472 Medi-Cal (50/50 Match State and Fed)
- Over 80% of the County's CHDP exams are provided by CommuniCare Health Centers.

Mental Health-Administer by County Alcohol Drug and Mental Health Department

Medi-Cal-Early and Periodic Screening, Diagnosis and Treatment (EPSDT) specifically for children that are Medi-Cal eligible Provides services for seriously emotionally disturbed (SED) children. According to the California Welfare and Institutions Code Section 5600.3(a) (2), seriously emotionally disturbed children are minors who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. If the county mental health department determines that a child meets the SED criteria, the department covers all outpatient services and inpatient services beyond the first 30 days for treatment of the SED condition.

- Services for Special Education students
- Children in acute psychiatric distress
- Contracts with community based organizations to provide services

DentiCal-Fee for Service Administered by DHS/EDS

Historically dental care has been a part of the Medi-Cal program since it began in 1966. However the formal DentiCal program began in 1974 with an initial pilot project

between Medi-Cal and Delta Dental. The relationship between DHS and Delta Dental continues to date. DentiCal is administered through a contract awarded from California Department of Health Services (DHS) to a managed care plan such as Delta Dental who administers their benefits and consumer relations. Delta then contracts with private providers on a fee for service basis.

DentiCal –A Barrier to Access

- Denial of essential dental services is the problem most frequently reported to the Health Consumer Alliance (HCA) and the Health Rights Hotline by Medi-Cal beneficiaries who are trying to access dental care. (Key Findings from DentiCal Denied, 2002)

- DentiCal beneficiaries who do not speak English experience significant difficulty communicating with their providers due to lack of language access at the dentist office and within the dental HMOs.

- Dental services for children are incredibly difficult to access under DentiCal because DHS has not implemented a process that allows providers a simplified billing structure.

- EPSDT services, which includes dental are not accessible to providers due to bureaucratic red tape and the denial of claims by CDHS.

- Providers often are misinformed about which dental services are covered under Medi-Cal and therefore may not submit requests for treatment authorizations.

Demographic Information (Please refer to Appendix A)

Population

The total Yolo County population is 184, 500 and of that 51,504 are children; 14,075 are 0-5 and 37,429 are 6-18. The children represent approximately 30% of each of the six major areas of Davis, Esparto, Knights Landing, West Sacramento, Winters and Woodland.

Poverty

Seventeen percent (17%) of Yolo County children live at 100% of the poverty line. The largest percentage (32%) of children living in poverty resides in West Sacramento. The lowest poverty rate is among children residing in Davis (7%). (CHIS, 2003)

Ethnicity

The majority of the county residents are Caucasian representing a range from 66% in Davis to 36% in Knights Landing. The second major ethnic group is Hispanics representing a high of 59% in Knights Landing and a low of 10% in Davis. (CHIS, 2003) (Yolo Co. Health Dept. MCAH Report, 2004)

Language Spoken at Home

All of the major areas in the county speak English at home, Knights Landing being the exception where 54% of the children speak Spanish at home. (Yolo Co. Health Dept. MCAH Report, 2004)

Births

Woodland leads the way in birth statistics in 2003 with 37% of all births in Yolo County, followed by W. Sacramento, 27%, Davis 26% and Winters .5%. Unfortunately, Yolo County is higher than the state average for infant mortality 6/1000. Additionally, in 2001 38 out of 1113 births at Sutter Davis were babies with low birth weight. This could indicate lack of access to prenatal care. (Yolo Co. Health Dept., 2003)

Prenatal Care

Sixty-five percent (65%) of pregnant women in Yolo County received adequate prenatal care from 1995-2001. The national goal is 90%. Factors such as poverty, recent

immigration and the lack of a medical home are possible factors that contribute to the overall lower percentage. (Yolo Health Alliance, 2003)

Emergency Room Utilization/Hospital Systems

Of all possibly avoidable emergency room child hospitalizations in 2002 43% were Medi-Cal children.) There were 3,755 children seen in the Sutter Davis ER last year. Approximately 184 of the children were uninsured. In FY00/01 Sutter Davis Hospital had an occupancy rate of 45% with approximately 18,200 ER visits of which nearly half 46% were for non-urgent reasons. In FY00/01 Woodland Medical Center had a 33% occupancy rate and approximately 67% with approximately 18,400 ER visits of which 67% were for non-urgent reasons. (Yolo Co. Health Dept. OSHPD, 2003)

Mental Health

Two Yolo County pediatricians have identified the growing number of children with behavior and/or possible mild mental health issues. They believe that service coordination, case management and patient navigation services are needed for pediatric mental health patients and their families. (Dr. March & Dr. Reinhart, personal communication, August 2004)

Basic Mental Health Services for mothers (Spanish speaking) was mentioned several times in the YCCFC Community Assessment, 2002. Parents who have less severe special need children are in need of assessment and referral to additional mental health services. (YCCFC Community Assessment, 2002) Parents who have substance abuse issues need culturally competent local services. Early intervention is critical in ensuring the long-term health of children. An Adverse Childhood Experiences (ACE) Study

published in the Journal of Preventative Medicine, found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. (Felitti, 2002)

Dental Health

The Yolo County Smile Savers program screened 1150 children 3-5 years of age in FY03/04. Approximately 25% had dental caries and 8% needed urgent care based on pain, or pulp involvement of one or more teeth. According to the California Health Interview Survey, 47% of uninsured low-income children 0-5 reported never seeing a dentist compared to 4.7% of insured children. (CHIS, 2003)

Provider Capacity -Geographic

Because of the collaborative nature of health systems in Yolo County medical access is adequate in most areas. However there are areas that could improve access. For example:

- West Sacramento Community Health Center is impacted and there are fewer providers (medical and dental) per capita.
- Esparto has a Community Health Center but the hours are frequently changed and the hours of operation are limited.
- Pharmacy services are limited in rural areas.
- In Winters there is no mental health or dental services for children or parents.
- In Clarksburg there is a clinic but it is on a cash only basis.
- There are very few pediatric dentists—even fewer who take HF or DentiCal.
- Pediatricians are concerned with the growing number of special needs kids that are in need of case management services to ensure appropriate treatment and referrals.
- Appointment wait times at CHC vary from 2-4weeks for medical and up to 3 months for dental. (except on an emergency basis) West Sacramento has the longest medical visit wait time at 4 weeks.
- Areas such as Dunnigan, Zamora, Yolo and other more rural townships have no doctors, dentist or mental health professionals to serve them. Transportation is also an issue.

Provider Mapping/Capacity

Below are both the Medical and Dental Provider Survey Summaries. All the doctors and dentists that were listed under pediatric, general or family practice were surveyed. There appears to be a large pool of doctors that are accepting new Medi-Cal and/or Healthy Families patients. However, there are specific geographic areas that are isolated such as Dunnigan, Yolo, Zamora, etc. CommuniCare has expanded services into Knights Landing and they are considering expanding capacity in West Sacramento were access is limited due to space constraints.

MEDICAL PROVIDER SUMMARY

	TOTAL	DAVIS	ESPARTO	KNIGHTS LANDING	WEST SACTO	WINTERS	WOODLAND
Number of medical providers	36	16	1	1	6	2	10
Number of medical providers accepting Healthy Families	26	9	1	1	5	2	8
Number of medical providers accepting Medi-cal.	33	13	1	1	6	2	10

- *Average wait time for appointments: 1 – 4 weeks.*
- *Number of providers offering services after hours: 11*

DENTAL PROVIDER SUMMARY

	TOTAL	DAVIS	ESPARTO	KNIGHTS LANDING	WEST SACTO	WINTERS	WOODLAND
Number of providers	63	29	0	0	1	2	31
Number of providers serving children 2 – 5	42	21	0	0	1	0	20
Number of providers accepting DentiCal	8	1	1	0	1	0	5

- *Average wait for appointment: 1 – 3 months*
- *Number of providers offering services after hours: 2 (both in Woodland)*

Mental Health Provider Capacity

Mental illness or behavior issues among children pose a significant risk to their emotional, cognitive and physical development that can lead to life long problems if intervention is postponed. (Fettiti, 2002) Currently, Yolo County is serving the majority of low income, Medi-cal eligible children with mental health problems but has limited capacity and is only mandated to see more advanced cases. There are only two psychiatrists in the county. Referrals to the County Mental Health Departments from Healthy Families increased by 71 percent (from 946 to 1,616) from the 2001/02 benefit year to the 2002/03 benefit year. (Healthy Families, 2004)

Dr. March, Associate Medical Director and Pediatrician for CHW, identified a gap in services for children with special mental/behavioral health needs. He stated there was a need for an assistant to help parents and providers navigate through the system to determine which programs the children are eligible for and to ensure their participation. (Dr. March, personal communication, August 2004)

Specialty Care

Yolo County has 62 dentists, however only 26 are willing to see children ages 2-5 years of age and only three will accept DentiCal with an average wait time over 3 months. The majority of public health providers, including school nurses, public health nurses and community health center staff, state that one of the greatest needs in regard to specialty care is to have a pediatric dentist that is willing to see low income uninsured or underinsured children.

Literature Review

Due to the federal and state programs like Healthy Families in California, the number of children without health insurance has declined. Despite this progress, many counties are struggling to care for its remaining uninsured. Gardner and Kahn in Assessing County Capacity to Meet the Needs of California's Uninsured: 2004 Survey Findings followed up on the survey they completed in 2002 with all 58 California Counties assessing each county's capacity to meet the need of the uninsured. The study was aimed at gaining information in regard to county programs that were focused on improving access to the uninsured and to assess current constraints and opportunities for insurance coverage programs. (Gardner & Kahn, 2004)

Gardner and Kahn (2004) report that there are currently 13 counties that have children's health expansion programs. Nine of the 13 counties are Healthy Kids programs that provide comprehensive insurance, which includes medical, dental, vision and mental health. Gardner and Kahn (2004) explain that counties have made significant progress in connecting people to insurance and services.

Gardner and Kahn (2004) explain that the presence of an access coalition played an important role in implementing programs for the uninsured. Out of the 44 counties who responded to this survey 29 responded that the access coalition was either important or very important. The counties with access coalitions had more coverage expansions underway than those without. This is particularly important as it supports the goal of the Yolo County Children's Health Coalitions, Healthy Kids program. In Yolo County, the Chair of the Children's Health Coalition is also a Board of Supervisors member. Gardner

and Kahn explain that the majority (36%) of the respondents believed that the BOS have a significant role and "can be key to launching a coverage expansion program, including the 'no resistance' to coverage expansion and participation in the planning and implementation program". (2004, pg. 9)

But expanding coverage for children does not come with out cost. Many of the Healthy Kids programs are relying heavily on Proposition 10 funds and private support from the Lucille Packard, California Healthcare and Blue Shield and The California Endowment foundations. (Gardner & Kahn, 2004) Gardner and Kahn explain "[o]ver all the prospects for increasing access to health care for the uninsured are encouraging despite significant financial constraints". (2004, pg. 5) Cunningham and Hadley (2004) in Expanding Care Versus Expanding Coverage study found that communities with a strong community health center presence and higher levels of insurance coverage tend to have the best access. However, insurance alone produces better results. Cunningham and Hadley (2004) state that the two strategies have distinct ways of increasing access. Health insurance targets a very specific audience, those who are currently uninsured. Expanding access through community health centers offers a very different alternative because it is not targeted specifically at the uninsured instead community health centers are located primarily in locations that are considered medically underserved. (Cunningham & Hadley, 2004) This would imply that insurance coverage would not necessarily provide improved access in rural areas where communities have insufficient provider capacity. (Cunningham & Hadley, 2004) Community health centers attempt to increase access to care based not on the uninsured but on the geographic service area were low income insured people may

not have appropriate access "...to other mainstream medical care providers or who face high out of pocket cost in using theses providers ... Research from the past thirty years shows conclusively that health insurance coverage has a strong effect on access to care". (Cunningham & Hadley, 2004, pg. 235) Cunningham and Hadley (2004) found that insurance coverage expansions are the most effective and efficient way to increase access to care among low-income populations due to the fact that the majority of uninsured people lack money, rather than doctors. Cunningham & Hadley (2004) explain:

> Interestingly, while greater investment in community health centers increase overall service use and may improve access to primary medical care (such as through more uninsured people having a usual source of care), continued lack of access to specialty services and providers may explain why high community health center capacity does not reduce use of the emergency department or unmet medical needs. (pg. 242)

Mathematica Policy Research Inc. findings from Examining Access to Specialty Care for California's Uninsured, (2004): Eighty-five percent of the community health center medical directors reported that their patients "often" or "almost always" have problems in obtaining specialty care;

> FQHC medical directors characterized adults' access as "often" or "almost always" problematic for 16 of the 24 specialties surveyed. Neurology, allergy/immunology, and orthopedics were among the specialties most frequently cited as problematic; and waiting times for the most problematic specialties are often months long, as shown by the case studies and the hospital outpatient department survey. (pg. 1)

Cunningham and Hadley (2004) explain that due to the fact that insurance expansion programs tend to target those with the greatest financial barrier, insurance programs have a natural advantage over community health centers. On the contrary, community health center expansions focus on increasing the availability of providers in urban and rural areas where there are few to none. "While such areas often have high

concentrations of very poor uninsured people, many, if not most, uninsured people live outside of these areas." (Cunningham & Hadley, 2004, pg. 242) Most uninsured people who live in the United States are working and therefore they more than often times live in urban and suburban areas that have not been federally designated as medically underserved and also have easy access to community health centers. (Cunningham & Hadley, 2004)

However, Cunningham and Hadley (2004) warn that insurance program expansions have limits. "Both public coverage and private coverage are voluntary, and many who are eligible for expansions choose not to enroll for a variety of reasons". (Cunningham & Hadley, 2004, pg. 242) Cunningham and Hadley (2004) explain that insurance premiums still may cost them too much or the plan may have high out of pocket co pays for services and therefore utilization rates would be lower. Either could present a barrier to overall improved access outcomes. In addition to costs, "[a]dministrative barriers in public programs (such as long application forms, face to face interviews, asset tests and six month re-determination periods, inhibit many eligible people from enrolling or reenrolling and non-citizens (that is recent immigrants)are often ineligible or afraid to enroll even if they meet all other eligibility requirements". (Cunningham & Hadley, 2004, pg. 242)

Cunningham and Hadley (2004) also suggest that insurance program expansions must ensure provider participation by ensuring appropriate reimbursement rates. They explain that most private providers have no incentive to accept MediCal because of the low reimbursement rates paid to them. Therefore, "...while coverage expansions generally are the most effective way to reduce financial barriers to care, new enrollees could still face other barriers to care and need to rely heavily of safety-net providers". (Cunningham &

Hadley, 2004, pg. 242) Cunningham and Hadley (2004) state that insurance program expansions should not be viewed as mutually exclusive. True, both approaches reap distinct benefits; insurance will provide the most benefit for those who live in communities were accessing providers is not an issue and community health centers deal with the opposite. Cunningham and Hadley (2004) suggest that with the revenue generated from insurance coverage expansions through reimbursements to counties could be bolstered to ensure safety net providers such as community health centers are sustained.

The Santa Clara County Children's Health Initiative was developed by a countywide coalition that brought together, community based organizations, county agencies and the local MediCal health plan to improve the health and well being of children in Santa Clara. (Trenholm, 2004) The Santa Clara Children's Health Initiative (CHI) has two parts: first, a new insurance product called Healthy Kids which covers the children that are ineligible for Healthy Families and MediCal but live below 300% of FPL and the second a comprehensive outreach and enrollment campaign that's message is that all children below 300% of the FPL are eligible for coverage. This campaign locates children and enrolls them in the public program that they are eligible for. Trenholm (2004) estimates that of the children who are uninsured, 66% qualify for existing public health programs.

Trenholm (2004) also suggest that an additional 16% are ineligible due to immigration status. Nationally, nearly 85% of children live in homes of mixed immigration status, that is, one sibling is a U.S. citizen and one or more is undocumented. That implies that children that are in the same family will not be eligible for the same

public programs. Trenholm's study findings indicate a direct coalition in offering an additional Healthy Kids product and increased enrollment in existing health programs. Trenholm found that for every child enrolled in Healthy Kids an additional child was added to Healthy Families or MediCal.

Trenholm (2004) explains that different factors may have lead to the increased enrollment in existing programs. Coordinated outreach is critically important. Coordinating the county's entire health and hospital system with the social service agency, health plans and community based advocacy organizations maximizes resources and effectively targets communities with large numbers of uninsured.

As important is the message that the CHI sent to Santa Clara families which is you bring your uninsured child and they will receive health coverage. Trenholm (2004) believes the change has reduced the confusion over program eligibility, a factor long identified as a major barrier to increasing MediCal and Healthy Families enrollment.

In Trenholm's 2005 study of the Santa Clara Children's Health Initiative, he explained, "...that Healthy Kids enrollees were children between the ages of 6-12, Latino and in good health". (pg.1) Children ages 6-12 make up the largest proportion of Healthy Kids participants (44 percent). Children birth to age five make up 21% of the enrollees because of the likelihood that they are born here and they are eligible for one of the publicly funded state plans. More than 80% of the Healthy Kids enrollees are Latino, most reside in non- English speaking homes.

Trenholm (2005) finds that unmet needs decline with Healthy Kids. Children who are insured by Healthy Kids showed a significant decline (from 22% to 10%) in unmet

needs across all four types of services investigated-well-child visits, sick child visits, and specialty care and prescription medications.

Access improves as it relates to a regular source of care as well. Healthy Kids increases from 50% to 89% the proportion of children with a usual source of primary care. Healthy Kids leads to even larger increases in access to dental care with the usual source of dental care jumping to from 29% to 81%. (Trenholm, 2005)

Use increases through Healthy Kids by the proportion of children who receive medical care. It rises from 30% to 54% with the most important increase in the number of preventative visits, which went from 24% to 43 percent. Another increase was in the proportion of children who received a sick child visit that increase from 16% to 34%. The number of children who sought care through a specialist increased from 4% to 11% with Healthy Kids insurance. (Trenholm, 2005)

By far the largest improvement was that made on the number of children access preventative dental care services. Without Healthy Kids, only 23 percent of children would have had preventative dental checkup. With Healthy Kids over 61% did. In regard to fillings or teeth pulled, the percentages nearly tripled with Healthy Kids from 15% before to 44% after. (Trenholm, 2005)

Parents are also more confident that they can obtain care when needed for their child—43% to 75%. "Satisfaction with care also improves under Healthy Kids. The percentage of parents who report being very satisfied with the care their child receives rises from 52% to 78% with Healthy Kids". (Trenholm, 2005, p.4) The percentage of parents

who are dissatisfied with the health plan drops from 13% to 2% with Healthy Kids. (Trenholm, 2005)

In a study commissioned by The California Endowment insuring children and youth brings state and federal resources into the state and county. (Finochhio, 2005) An evaluation of the Santa Clara County Children's Health Initiative found that increased participation for children and youth in MediCal and Healthy Families brought in over $24 million dollars in state and federal resources to the county. "For every child enrolled into MediCal or Healthy Families, the county will bring in an estimated $1,112 annually in state and federal dollars". (Finochhio, 2005, pg. 2) For Yolo County, it is estimated that creating a Healthy Kids product and following the same core principles of Santa Clara County Children's Health Initiative could bring in the county nearly $2 million of combined state and federal funding. Of that, it is estimated that $373,000 will be brought in to primary care physician services, $235,000 for specialty care services, $294,000 for hospital services $98,000 for pharmacy services, $549,000 for dental services, $39,000 for vision services and $78,000 for health plan administrative fees. (Finochhio, 2005)

Kingdon (2003), in his book titled *Agendas, Alternatives, and Public Policies* describe policy entrepreneurs as being a person or group of persons who know there is a problem and are willing to invest their resources, energy, reputation and money on the hope of a solution. Clearly, the local CHIs, which include countywide coalitions and philanthropic foundations such as The California Endowment, The Packard Foundation, The California Wellness Foundation and the Blue Shield Foundation and Senator Escutia and Assembly member Chan are such entrepreneurs.

Research Methods

The objective of this study was to investigate whether parents perceived that a Healthy Kids insurance product would improve access to healthcare services for their children through the following hypothesis: Offering Yolo County low-income children who are currently uninsured and do not qualify for MediCal or Healthy Families a Healthy Kids insurance product will be perceived by parents to improve access to health care services. The independent variable is offering uninsured low-income Yolo County children ages 0-18 a Healthy Kids insurance product correlating with the dependent variable, which is a perceived benefit by parents that Healthy Kids health insurance will improve access to health care services. Understanding that not all who participated in this study completely understood the complexity and context of the measurement of the data, operational definitions were provided.

Operational Definitions

For the purposes of this study, low income represents families whose annual income is at or below 300% of the Federal Poverty Line. Please refer to the table below, which numerates the FPL. For example a household with four members, which could be one parent and three children or two parents and two children must make below 56,592 annually to qualify for Healthy Kids.

Household Size	100% FPL	300% FPL
1	9,312	27,936
2	12,504	37,512
3	15,672	47,016
4	18,864	56,592

The scope of benefits that the Healthy Kids insurance product provides is equivalent to the scope of benefits provided through Healthy Families. Below is the proposed scope of benefits as it compares to Healthy Families:

Benefit	Description/Limitations	Healthy Families	Healthy Kids County CHI
Preventive Health Services	• Well-baby exams, under 24 months • Periodic health examinations • Immunizations • Variety of voluntary family planning • Vision and hearing testing	√ √ √ √ √	√ √ √ √ √
Medical and Surgical Services	• Office visits • Consultations or second opinions • Outpatient office surgery • Allergy testing & treatment, including injections and serum • Inpatient medical and surgical physician services • Professional services for the treatment of mental health, alcohol and drug abuse	√ √ √ √ √ √	√ √ √ √ √ √
Inpatient Hospital Services	• Inpatient – room and board, general nursing care, ancillary services, prescribed drugs, laboratory, and radiology, physical, occupational, and speech Therapy.	√	√
Outpatient Hospital Services	• Services and supplies for treatment or surgery	√	√
Diagnostic X-ray and Laboratory Services	• Therapeutic and radiological services	√	√
Pregnancy & Maternity Care	• Professional and inpatient hospital services including prenatal and postnatal care, newborn and nursery care	√	√
Family Planning	• Variety of family planning services including counseling, surgical procedures, contraceptives and abortion services	√	√
Diabetes Management & Treatment	• Services and supplies for the management and treatment of diabetes	√	√
Skilled Nursing	• Medically necessary skilled nursing care	√	√

Benefit	Description/Limitations	Healthy Families	Healthy Kids County CHI
Care			
Home Health Services	• Nursing care • Physical, occupational and speech therapy	√	√
Hospice Services	• Including nursing care, home health services, physician service drugs, counseling and bereavement services,	√	√
Prescription Drug Coverage	• 30 – 34 day supply generic medications • Oral & injectable (i.e., Norplant) contraceptive drugs and devices & emergency contraceptives • One cycle of tobacco cessation drugs per benefit year (members must attend tobacco use cessation classes or program) • Inpatient drugs	√ √ √ √	√ √ √ √
Emergency Health Coverage	• 24-hour care for emergency health care services	√	√
Ambulance Services	• Ambulance transportation when medically necessary	√	√
Mental Health Services	• Inpatient mental health care • Outpatient mental health services	√ √	√ √
Alcohol/Substance Abuse Treatment	• Inpatient and outpatient services	√	√
Durable Medical Equipment	• Medical equipment, oxygen and oxygen equipment, insulin pumps and all related necessary supplies	√	√
Orthotics and Prosthetics	• Medically necessary replacement orthotic and prosthetic devices as prescribed by a HPSJ provider.	√	√
Reconstructive Surgery	• Services related to surgery to performed to correct or repair abnormal structures of the body,	√	√
Organ Transplants	• Medically necessary organ and bone marrow transplants	√	√
Hearing Aid Services	• Hearing aids/services – audiological exam, hearing aid evaluation, monaural or binaural hearing ancillary equipment and office bisits	√	√
Vision Care	• Cataract spectacles, cataract contact lenses, intraocular lenses or conventional eyeglasses or contact lenses as necessary after cataract surgery.	√	√

Benefit	Description/Limitations	Healthy Families	Healthy Kids County CHI
Blood and Blood Products	• Processing, storing, administering, as well as collecting and storing of autologous blood	√	√

The term improve represents that at least 10% of parents will agree that Healthy Kids will improve access to Health care. For the purposes of this study, access to healthcare refers to the establishment of a regular source of care, i.e. medical home, decreased wait times to access services and not delaying care when needed.

Sampling Methodology

The target population was parents with uninsured children 0-18 whose income was at or below 300% of the Federal Poverty Line and who were residents of Yolo County. The total target population was approximately 1,200 families. Families were identified through secondary data collected through the California Department of Labor, Yolo County Public Health's Epidemiolgy Department which identified where the largest number of children resided who were most likely to be representative of the target population. The researcher also used the knowledge and expertise of a community engagement specialist that was able to identify specific parent groups who were representative of the target population. "The main criterion for selection of any unit from the population using this sampling procedure is the investigator's judgment that the unit somehow represents the population." O'Sullivan, Rassel, and Berner, 2003, p. 147)

Therefore, the primary investigator, having experience working with the target group used knowledge and judgment about the target population when choosing where to sample. The researcher chose a non-probability purposive sample of 135 qualified

research participants. The researcher wanted to ensure that the sample population was representative and designed to give each qualified research participant the likelihood of being selected therefore they made sure that both rural and urban locations were chosen.

Data Collection

Through a case study approach, the benefit of Healthy Kids insurance product was examined utilizing both primary and secondary data sources. Relevant literature including studies of the existing Healthy Kids program in Santa Clara County were analyzed to determine the extent that Healthy Kids could improve access to healthcare. Results from the April, 2005 Mathematica study found that with Healthy Kids the number of kids who see a regular doctor for care improves by 39%, from 50% without Healthy Kids to 89% with. Delaying care is cut in half, from 22% delaying care prior to Healthy Kids to 10% delaying care after. The proportion of parents who are confident that they can get the care they need for the child improves by 32%, from 43% before Healthy Kids and 75% after its implementation.

Primary data was collected through a survey utilized to gather qualitative data that measured the perception regarding Healthy Kids insurance and the level of improved access to healthcare. A typed-written questionnaire (Appendix B) was developed to determine perceptions regarding offering Healthy Kids and improved access to healthcare. The questionnaire was completed through person interviews with over 400 Yolo County residents. Through the initial three qualifying questions 135 qualified participants surfaced. The researcher was identified as a Golden Gate University graduate student who was completing a research project in regard to children's health insurance. Each survey

outlined that it was voluntary and confidential and if they choose to receive a copy of the research document once completed it would be provided to them.

Interviewers assisted the participants on a one-on-one basis. The questions were designed to ensure consistency with the purpose of the study, measure the variables, and substantiate reliability and operational validity. (O'Sullivan, Rassel, and Berner, 2003.) The first three questions were used to qualify participants and ensure they were representative of the target population by identifying that they have children that were uninsured and not eligible for existing programs such as MediCal and Healthy Families and where their income was below 300% of the FPL. The remaining five questions of the questionnaire sought to determine the perceived benefit that insurance will improve access to healthcare services i.e. establishing a medical home, decrease wait times to access services and not delaying care when needed. Through the use of Likert scale questioning, the researcher was not only able to establish whether the participants agreed that there was a perceived benefit, but the strength of the qualified research participant's perception. Questions four through eight were specifically related to the research hypothesis that theorized offering a Healthy Kids insurance product would increase access to healthcare.

The researcher attempted to complete as many surveys as possible within 45 days. As surveys were collected they were placed in a folder to be analyzed after all interviews were completed within the time line. Once the timeline was completed, survey data were recorded and analyzed using Excel spreadsheet software that was able to quantify results once a formula was entered. The data was summarized based on the frequency distribution (percentages in each category) and the mode, which is the term used to describe the most

common category selected, was calculated (Leedy and Ormord, 2005). For question seven, an ordinal scale was utilized and the data was summarized as the percentage of participants who did or did not delay care based on inability to pay. The median, which indicates the center or mid-point of the distribution, and the mode were calculated (Leedy and Ormord, 2005).

Internal Validity

The results of this study may be viewed within the context of the limits of a non-probability purposive design on internal validity. The research depended on the researcher's judgment at identifying specific locations to be used to locate qualified research participants versus a sample of the entire county. However, with that said, threats to internal validity were minimized by ensuring that a cross-section of the population based on certain demographic information such as poverty was representative of the target population.

External Validity

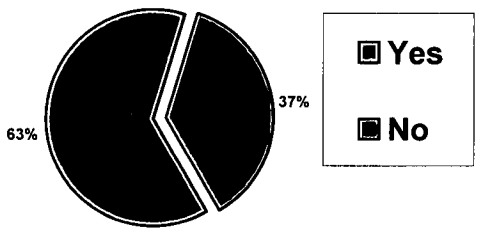
The results of this study may be viewed within the context of its limitations of external validity as Yolo County represents a largely rural small county. The findings imply that another small rural county with the similar demographics can replicate this study.

Results and Findings

The objective of this study was to investigate whether parents perceived that a Healthy Kids insurance product would improve access to healthcare services for their children through the following hypothesis: Offering Yolo County low-income children who are currently uninsured and do not qualify for MediCal or Healthy Families a Healthy

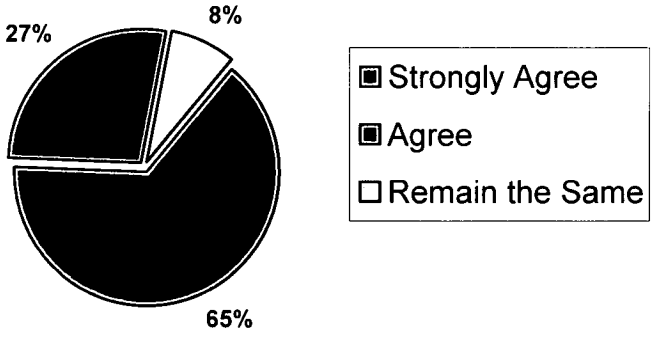
Kids insurance product will be perceived by parents to improve access to health care services.

Figure 1. Parents have delayed their child's care due to inability to pay.



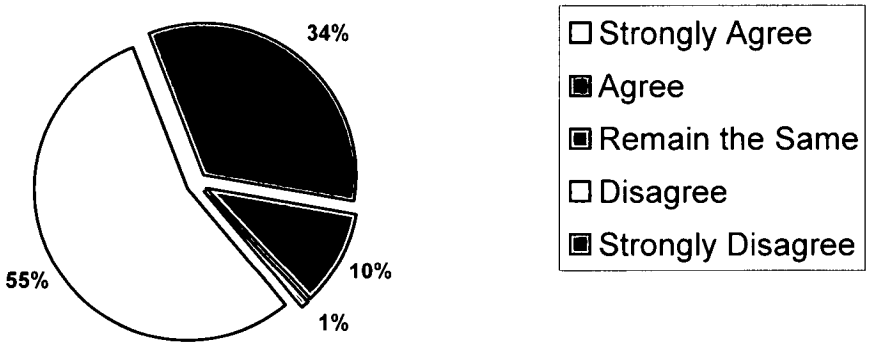
This question was used as a base line question to establish delay of care. Figure 1 illustrates that 63% (n=85) of parents have at some time delayed care for their children because they did not have enough money to pay. The remaining 37% (n=50) did not delay care for their children based on an inability to pay. The secondary data collected through Trenholm (2005) does not specifically identify the parent's delay was due to inability to pay, that being said, delaying care was cut in half, from 22% delaying care prior to Healthy Kids to 10% delaying care after.

Figure 2. If insured believe children would receive timely medical and dental care.



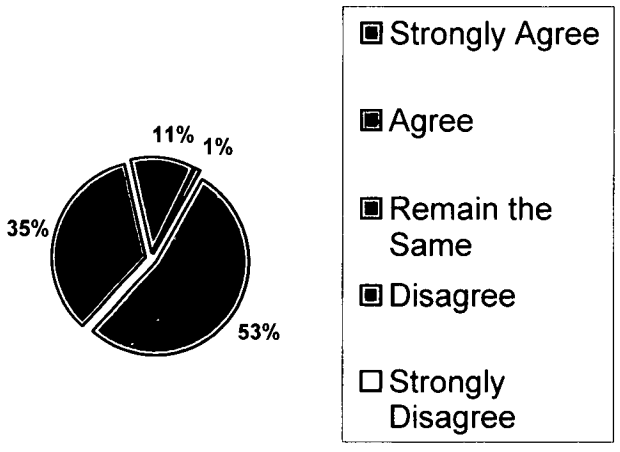
This question was asked in order to determine whether parents viewed having Healthy Kids insurance would assist them in not delaying care and ensuring that there children would receive timely medical and dental care. Over 92% (n=124) of Yolo County parents agreed that if their children had a Healthy Kids insurance product it would improve timely access to medical and dental services for their children. Approximately 8% (n=11) believed that having Healthy Kids would not make a difference in whether their child received timely medical care. In Santa Clara unmet needs decline with Healthy Kids. (2005) Children who are insured by Healthy Kids showed a significant decline (from 22% to 10%) in unmet needs across all four types of services investigated well-child visits, sick child visits, and specialty care and prescription medications. (Trenholm, 2005)

Figure 3. If insured parents would choose regular source of care.



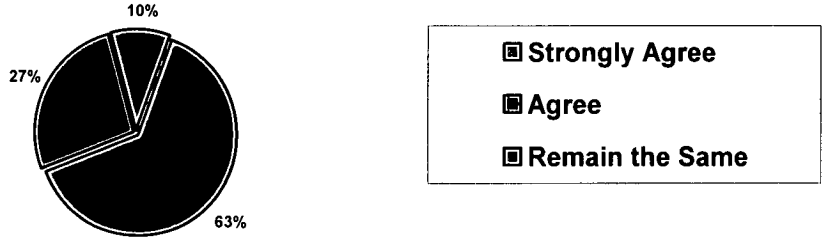
Access to a regular source of care is a cornerstone to child health services. "Once services can be accessed, actual health care delivery becomes possible". (Chung & Schuster, 2004, pg. 77) Figure 3 demonstrates that 55% (n=74) strongly agreed that having Healthy Kids insurance would increase the possibility of their children establishing a medical home. Thirty-four percent (n=50) also agreed that it would improve their ability to choose a regular source of care and ten percent (n=13) believed that it would not increase the likelihood that they would choose a regular source of care. One parent (>1%) strongly disagreed. This percentage more than substantiates the hypothesis that 10% of parents would believe that Healthy Kids would improve access to healthcare. According to Chung et al. (2005) a regular source of care promotes well-child care (delivered mostly through pediatricians and family practioners) and its primary goal is to prevent illness and promote health through immunizations, routine check ups and guidance. Trenholm (2005) reported that children that enrolled in Healthy Kids in Santa Clara County nearly doubled the amount preventative care visits from 24% to 43% with Health Kids.

Figure 4. If insured believe it would increase number of health care providers to choose from.



This question is particularly important as it relates to specialty care and dental care access. Many children who have chronic illness such as diabetes and asthma need to be treated by specialist in order to manage the negative effects of the disease. Over 88% of parents surveyed agreed that having Healthy Kids insurance would increase the number of providers to choose from. Many parents made comments in regard to dental care providers often do not see uninsured individuals unless they can pay in full. Just over 10% believed that the number of providers would remain the same and less than 1% disagreed. The issue of access for many in rural communities should not be ignored. "Access to consistent primary care may be affected by issues such as the number of providers in underserved communities, choice of providers, availability of interpreter services and cultural sensitivity among providers". (Chung, 2005, pg. 81) Many of the parents surveyed lived in rural communities where medical and dental providers were limited. However, many who lived in medically underserved areas had access a to a federally qualified community health center.

Figure 5. If Insured Believe that the Wait Time to Receive an Appointment Would Be Decreased



This research question was asked in order to gain understanding as to whether parents perceive that waiting to schedule an initial appointment with a doctor will be decreased it they have insurance. This addresses a key issue in how easy it is for parents to access care when a child is sick. Not being able to access a doctor in a timely manner can lead to over utilization of emergency rooms for non-urgent reasons. As mentioned previously in the background section of this paper, over 50% of all children's emergency room visits in 2003 at Yolo County hospitals were for non-urgent reasons. Figure 5 illustrates that 63% (n=85) of parents strongly agreed that having Healthy Kids insurance would decrease wait times to see a doctor. Just over 27% (n=36) agreed and approximately 10% (n=13) believed it would stay the same.

Recommendations for Further Research

It is important to note that over 65% of the survey participants had children of mixed immigration status. That is where one child, usually the younger, was born in the United States and is a citizen and the other sibling(s) are not. It appears that in families of mixed immigration status, eligible children are less likely to be enrolled if their siblings are

denied coverage. Many of the parents after completing the survey stated this as being a barrier. As important is the message that Santa Clara Children's Health Initiative sent to families, which is all uninsured children in a family will receive health coverage. It is important to research whether opening up enrollment for all children increases the amount of children enrolled or if the increased enrollment is due to the increase level of culturally appropriate outreach.

DentiCal continues to be a program that is accepted by few dentists in Yolo County. It may be due to the administrative bureaucracy that is explained in DentiCal denied. This needs to be researched further. As mentioned previously there are over 16,000 children who currently have MediCal and therefore, DentiCal. In Yolo County, only three dentists will see DentiCal patients. They are all located at the community health centers. Further study is recommended to better assess the current issues with dentist acceptance of DentiCal in Yolo County in order to identify barriers and potentially improve access for MediCal children.

The same issue holds true for mental health services. Although insurance improves access, it will only improve access if providers are available to serve the growing number of children with behavioral/mental health issues. (Healthy Families, 2004) It is recommended that innovative ways be explored to increase the number of mental health practioners in Yolo County.

Public Policy Recommendations

Healthy Kids is a widespread action by counties that is now creating the momentum for statewide policy. Support SB 437 and AB 772 to ensure all California

Children. Senator Escutia SB 437 and Assembly member Chan AB 772 have sponsored legislation to establish one statewide program known as California for Healthy Kids. There are several components that will need to be addressed by SB 437 and AB 772. Senator Escutia and Assembly member Chan will need legislation detailing the way that Healthy Kids will be administered. Currently, MediCal is a state and federally-funded (50/50 match) program that provides health care coverage for low-income people who lack health insurance. The United States Department of Health and Human Services, Center for Medicare and Medicaid (MediCal) provides regulatory oversight such as waivers and state plans. The California Health and Human Services Agency Medical Care Services Division, directly administers MediCal.

One of the largest components of the transition from the locally operated Healthy Kids Programs to the Statewide California for Healthy Kids program will be its managed care administration. Currently, California operates under four different forms of managed care: Geographic; County Organized Health System, Fee for Service and Two plan models. The administration is different for both health plans and provider groups. The advocates for this statewide policy which are local CHIs, the 100% Campaign, PICO, Children Now and Children's Partnership will need to assist the legislators with language development in order to ensure the statewide Healthy Kids builds on the existing Healthy Kids program rationales. Implement a Healthy Families look a like benefit package because this structure has been well received by families and providers and has been successfully adapted in Healthy Kids counties. Ensure that the statewide Healthy Kids program will incorporate MediCal, Healthy Families and Healthy Kids managed care

networks, with an emphasis on including public managed care and safety net providers—and sustain local contracts for at least five years. Continue the family low share of costs except for those families below 133% FPL. Those families should have no share of cost.

There continues to be the need to centralize eligibility determination, this has the potential of creating administrative efficiencies and improving enrollment and reenrollment rates. It is known that due to inflexible and complicated reenrollment processes children are unnecessarily dropped from coverage, only to reenroll them at a later date at twice the cost. In a study commissioned by The California Endowment it is estimated that it cost the state of California approximately $180 each time a child is dropped off of coverage to just be reenrolled at a later date. "This means that California is spending over $120 million to re-process eligible children who have been disenrolled in a three year period." (Fairbrother, 2005, p.7) Addressing the problem of children losing coverage will have the probability of an enormous cost savings.

Language would also need to include local control and coordination of outreach, enrollment, utilization and retention activities. In counties with a local managed care plan (Yolo), the state would need to cap private health plan membership so that the majority of members are directed to COHSs. Many of these plans have already started local Healthy Kids programs (Yolo, Solano, Sonoma, Napa, Santa Cruz, San Mateo, etc.). The local health plans have invested millions of dollars to develop and implement these programs and deserve to continue to accrue a return on the investment under a statewide program.

In addition to administrative problems, which are the most common causes of coverage loss, renewal/reenrollment application processes are confusing and complicated.

Incorporate technology through One e App, which is a web-based system that is designed to screen and enroll applicants in multiple public programs for which they may be eligible in a single application. Some of the benefits would include:

- Improved consumer access to a range of state and local health programs
- Create efficiencies by reducing repetitive manual data entry and improving quality of data.
- Provide a countywide database for outreach and ongoing retention rates.
- Controlled by individual counties.
- Can be customized to fit specific county program data collection needs.
- Interface with state, county and other IT systems.

An additional issue and possibly the most controversial, is whether legislators will agree to use public funds for undocumented children. There is still a great deal of analysis needed on the actual cost savings element. Currently, undocumented children receive services through Children's Health and Disability Program (CHDP) and emergency MediCal. The argument that will need to be proven is how much money will be saved by providing preventative health care instead of higher cost care for emergency services. It is clear however, that the local level initiatives insure all children regardless of immigration status and their support of the California Healthy Kids model will require the same.

The employment side will also need to be explored more thoroughly. Big business may not oppose assisting with funding some of this at the state level if it is not a mandatory requirement. They may even support it so that SB2 does not reappear. This will also need to be explored as an alternate component. Currently, United Way has been funded to engage big business and explore ways in which they can contribute on a voluntary basis.

It could be perceived that taking the time now to collapse programs like Healthy Families, MediCal and Healthy Kids into one program will demonstrate that a single payor system for all Californians could and should be adopted. The Lewin Group, in 2004 provided an analysis of the cost effectiveness of Senator Kuehl's proposed legislation SB 840 and the results were phenomenal. The bill will insure every Californian resident with comprehensive health insurance while guaranteeing their right to choose their own physician. "By slashing the administrative costs of health insurance and utilizing California's purchasing power to buy prescription drugs and medical equipment in bulk, CHIRA will save an estimated $25 billion, in the first year alone, in statewide healthcare spending. " (Press Release, 2005) SB 840 will fold all public and private insurance into one single payor product that is administered b the government and will include employers contributing.

An alternative approach that was used in the early 1990's and is still being pursued to date is the employer-provided insurance through the play or pay model which requires employers to either pay for the health insurance of its employees or pay a tax that will fund it. This model has been used over the last two decades and businesses have succeeded in attempts to avoid mandatory financial participation.

There have been several attempts to overhaul the health care system in the United States. The legislation analyzed here is just a microcosm of a large and complex issue. However, what is apparent is the market failure and more importantly, government failure by failing to intervene in a market that has gone out of control. Weimer and Vining explain "[s]ome market failures are simply too costly to correct; some distributional goals

are too costly to achieve. More fundamentally we do not know how government intervention will work out ... [e]nthusiasm for perfecting society through public intervention, therefore, should be tempered by an awareness that the costs may exceed the benefits." (2005, p. 157)

Although the costs analysis of providing one million children with coverage has begun, it is not completed. It is unofficially estimated at costing the state 600 million dollars. The advocacy groups such as CHI Directors, 100% Campaign, PICO, Children Now and Children's Partnership are completing some initial polling to see if California's would consider a form of candy tax to support this endeavor. The initial polling results are good.

Summary and Conclusion

The health care system for the poor and uninsured is complex and fragmented to say the least. Each separate program has a different administrative structure that enforces regulations that are designed to ensure that only specific people will receive a distinct set of services. It is a maze of patch worked programs that prevent people from accessing the services for which they may be eligible. However, programs such as Healthy Kids have the ability to simplify enrollment processes and administrative bureaucracy.

There are currently nine counties in California that with the financial assistance of First Five Commissions, County TLS (Tobacco Litigation Settlement) and general fund dollars and foundation support (such as Packard, The California Endowment, California Healthcare Foundation and Blue Shield Foundation) has been able to provide insurance coverage for nearly all the uninsured children 0-5 in their counties. The majority of CHIs have elected to mirror the Healthy Families scope of benefits. The eligibility requirements are expanded to include all

children regardless of immigration status and most counties have opted to increase income guidelines from 250% to 300% of the federal poverty level.

Due to the fact that there are over twice as many children from the ages of 6-18, coupled with the likelihood that the older children are less likely to be legal residents, the number of children who do not qualify for existing health programs in that age range is significantly higher and somewhat unpredictable. Currently there are large foundations that have committed to subsidizing insurance premiums for children 6-18 years old. In exploring funding options, YCCFC staff had telephone conferences with both the Blue Shield Foundation and The California Endowment. Both are planning to continue to fund subsidies for children until there is a State policy implemented to ensure universal health care for children.

Healthy Kids is working in Santa Clara to improve access to healthcare for low-income children. Parents in Santa Clara feel more secure that their children will receive the care they need through Healthy Kids. The parents in Santa Clara have also shown that it has increased their ability to provide timely care. (Trenholm, 2005) In Yolo county parents believe that Healthy Kids will improve access to healthcare by establishing a regular source of care, decreasing wait times and not delaying care when needed. The hypothesis has been supported through both primary data collected and secondary data collection and review.

State wide policy advocates such as the county CHI Directors, 100% Campaign, PICO, Children Now and Children's Partnership will need to continue to support Senator Escutia and Assembly member Chan to design legislation that continues to build upon the local CHI successes and will streamline and increase enrollment of children into health programs. Incrementally this movement could pave the way for Californians to eventually

establish universally healthcare for all. Our children are our future. If we do not invest in them who will? The themes are clear, cover all children ages 0-18 who are uninsured reside in California and whose family's income is at or below 300% of the FPL. Retain them in these programs by simplifying eligibility reenrollment requirements.

The Healthy Kids model reflects the type of policy that Kingdon explains, "...captures a fundamental reality about an irresistible movement that sweeps over our politics and our society, pushing aside everything that might stand in its path." (2003, p.1)

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*A note of thanks to all of you who graciously took the time to meet with me and who put up with my many calls and emails requesting just one more thing... Your dedication to your profession and to the children of Yolo County is admirable.

Informal Interviews:

Thompson, Helen	Supervisor, Board of Supervisors Commissioner, Chair
Hinton, Bette	Health Officer, YC Health Dept, Commissioner.
Rose, Jerry	Director YC DESS, Commissioner
Rodriguez, Irma	YC ADMH, Commissioner
Heitman, Sue	YC Health Dept. Commissioner District 5
Affrime, Robin	CommuniCare Health Centers
Babb, Jan	CHDP
Boney, Cheryl	YC Health Department
Clarkson, Roger	YC Health Department
Corda, Traci	California Children's Services.
Craig, Renee	YC DESS
Deats, Phyllis	Family Resource Center Knights Landing
Diel, Mark	Get Ready, YC Health Dept.
Finocchio, Len	Institute for Health Policy Solutions
Gibboney, Liz	Partnership Health Plan
Hrivnak, Alida	Yolo County Health Dept.
Long, Peter	The California Endowment
Lopez, Janette	MRMIB
March, Thomas	Pediatrician, CHW
Nevraumont, Donna	Public Nursing, YC Health Dept.
Pozgayova, Terezia	Washington Unified School District
Pfeifle, Rebecca	YC DESS
Rock, Sarah	Yolo County Family Resource Center
Reinhart, Michael	Pediatrician, Sutter West Medical
Slater, Jana Kay	Consultant
Taylor, Stella	Woodland Joint Unified School District
Wagner, Janet	Sutter Health
Wicks, Cathie	RISE, Inc.
Wilson, Tim	YC Epidemiologist

Appendix A

	County Wide	Davis	Esparto (95627)	K.Landing (95645)	West Sacto	Winters	Woodland	Other Cities
Total Population	184,500	64,500	3,010	1,945	38,000	6,875	52,500	17,670
Child Population								
Total # of Children	51,504	16,378	993	641	11,651	2,268	16,299	3,274
0 - 5	14,075	2,966	327	211	3,627	748	5,378	818
6 - 18	37,429	13,412	666	430	8,024	1,520	10,921	2,456
Child Poverty Levels								
Ages 0-18	Poverty Distribution By City							
17% 0 - 100% FPL	8,756	7%	13%	13%	32%	5%	15%	15%
12% 101-150% FPL	6,180							
11% 151-200% FPL	5,665							
14% 200-300% FPL	7,210							
Ethnicity								
White	58%	66%	56%	36%	55%	51%	53%	57%
Hispanic	26%	10%	37%	59%	30%	44%	39%	27%
Asian/PI	10%	17%	2%	1%	8%	1%	4%	10%
Black	2%	2%	1%		2%		1%	3%
American Indian			1%			1%		
Multiple Race	3%	4%	2%	2%	4%	2%	2%	2%
Other	1%	1%	1%	1%	1%	1%	1%	1%
Language Spoken at Home								
English	68%	76%	64%	45%	62%	61%	65%	68%
Spanish	19%	7%	33%	54%	20%	37%	30%	19%
Chinese	3%	6%						3%
Vietnamese		2%						
Russian	2%				8%			2%
Indic: Urdu, Hindi	2%				2%		2%	
Hmong					2%			
Other	6%	9%	3%	1%	6%	2%	3%	8%
Uninsured Children		Low 7%	Median 10%	High 13%	Uninsurance rate low 7% Reg. Average 10%/High State 4%			
0 - 5 years	**Total**	985	1,406	1,829				
	Eligible M/C	424	605	786	43% eligible MC due to age appr.prog.& leg.res. status.			
	Eligible HF	276	393	513	Approx. 28% eligible.			
	Ineligible	285	408	530	Approx. 29% ineligible based on tot. % of children in category.			
6 - 18 years	**Total**	2,620	3,743	4,866				
	Eligible M/C	786	1,122	1,460	Approx. 30% eligible.			
	Eligible HF	865	1,236	1,606	Approx. 33% eligible.			
	Ineligible	969	1,385	1,800	Approx. 37% ineligible based on tot. % of children in category.			
0 - 18 years	**Total**	3,605	5,149	6,695				
	Eligilble M/C	1,210	1,727	2,246				
	Eligible HF	1,141	1,629	2,119				
	Ineligible	1,254	1,793	2,330	Approx.33-35% ineligible based on state wide data.			

Appendix B

Esta inquesta es parte de un proyecto de investigacion academica llevada acabo por medio de un estudiante de la Universidad de Golden Gate. Su participacion seria completamente confidencial y voluntariamente. Una copia de la declaracion de confidencialidad y seguridad sera disponible si la solicta. Adicionalmente, si usted esta interesado en obtener una copia del proyecto, por favor avisele a la persona que esta dirijiendo la inquesta para proveerle una. Estas preguntas **se refieren o tienen que ver con el** seguro de salud de los ninos.

1) Tiene ninos entre las edades de 0-18 que no tienen seguro?

SI NO si la respuesta es NO=paren

2) Califican para el programa de Healthy Families o programs de Medi-Cal?

SI NO No se

3) Cuantos miembros hay en su familia inmediata? Que es su salario familiar? *

2 meimbros en familia - $38,000 per year

3 meimbros en familia - $48,0000 per year

4 meimbros en familia - $57,000 per year

5 meimbros en familia - $67,000 per year

6 meimbros en familia - $76,000 per year

7 meimbros en familia - $86,000 per year

8 meimbros en familia - $94,000 per year

4) Piensa usted que teniendo seguro de Healthy Kids, le aumenta la cantidad de doctores o servicios de donde escojer.

a) muy de acuerdo
b) de acuerdo
c) igual
d) desacuerdo
e) muy en desacuerdo

* Para el proposito de esta inquesta, familia inmediata se considera los padres y hijos/as que viven en la misma casa.

5) Cree usted, que si tuviera seguro de Healthy Kids, iria con mas frequencia y mantendria el mismo doctor para su nino/a?

a) muy de acuerdo
b) de acuerdo
c) igual
d) desacuerdo
e) muy en desacuerdo

6) Cree usted que si tuviera seguro de Healthy Kids seria mas facil de ver a un doctor o dentista?

a) muy de acuerdo
b) de acuerdo
c) igual
d) desacuerdo
e) muy en desacuerdo

7) A tardado en llevar a su hijo/a al doctor por que no tenia seguro de Healthy Kids y no podia pagar por el servicio?

SI NO

8) Cree usted que si tuviera seguro de Healthy Kids, iria a los chequeos que estan programados para mira el desarollo de su nino/a?

a) muy de acuerdo
b) de acuerdo
c) igual
d) desacuerdo
e) muy en desacuerdo

Appendix C

This interview is being conducted for the purposes of an academic research project which is being conducted by or on behalf of a graduate student at Golden Gate University. Your participation in this survey is completely voluntary and confidential. A copy of the confidentiality and security statement is available upon request. Additionally, if you are interested in obtaining a copy of the final capstone project, please let the interviewer know and one will be provided to you. These interview questions pertain to children's health insurance. Healthy Kids for the purposes of this study has the exact medical, dental and vision care coverage for children that Healthy Families does. It costs $7 a month per child and provides inpatient, outpatient and preventative comprehensive care for children. The maximum a family can pay is $28 for all children in a family. The co pay amount for doctors visits does not exceed $5 a visit

1) Do you have children ages 0-18 that are currently uninsured?

Yes **or** **No** **IF NO--STOP**

2) Are you qualified for the Healthy Families or Medi-Cal public health programs?

Yes **No** **Don't know**

3) How many members do you have in your immediate family? * **Does the number of your family members and income fall below?**

2 - $38,000 per year **IF NO--STOP**

3 - $48,0000 per year

4 - $57,000 per year

5 - $67,000 per year

6 - $76,000 per year

7 - $86,000 per year

8 - $94,000 per year

4) Do you believe that having Healthy Kids insurance would provide you with an increased number of health care providers to choose from?

a) Strongly Agree
b) Agree
c) Remain the Same
d) Disagree
e) Strongly Disagree

* Immediate family for the purposes of this survey is the parent(s) and their children living in the same home.

5) Do you believe that Healthy Kids insurance would increase the probability that your child would visit a regular doctor for care? (medical home)

a) Strongly Agree
b) Agree
c) Remain the Same
d) Disagree
e) Strongly Disagree

6) Do you believe that if you had Healthy Kids insurance it would lessen the amount of time that your child would wait to receive an appointment with a doctor or dentist?

a) Strongly Agree
b) Agree
c) Remain the Same
d) Disagree
e) Strongly Disagree

7) Have you ever delayed taking your child to a doctor because you did not have insurance for your child and you could not afford it right then?

Yes **or** **No**

8) Do you believe that if you had Healthy Kids insurance you would increase the probability that your child would receive timely medical and dental attention?

a) Strongly Agree
b) Agree
c) Remain the Same
d) Disagree
e) Strongly Disagree

Appendix D

EMPA 396 Capstone Gantt Chart

	OCTOBER		NOVEMBER				DECEMBER			MARCH			APRIL				MAY		
TASK LIST	Week 2	Week 3	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3
Define Research Question																			
Prepare Hypothesis																			
ID Independent Variable																			
ID Dependent Variable																			
Operationalize Concepts																			
Gather Secondary Data																			
Gantt Chart																			
Draft Abstract																			
Draft Introduction																			
Draft Research Methods																			
Submit Research Proposal																			
ID Control Variables																			
Gather Primary Data																			
Identify Sample Population																			
Develop Survey																			
Administer Survey																			
Analyze Findings																			
Check Internal Validity																			
Check External Validity																			
Verify Hypothesis																			
Complete Introduction																			
Complete Literature Rev.																			
Complete Research Meth.																			
Develop Results & Findings																			
Complete Summary & Findings																			
Prepare Further Recommendations																			
Complete Bibliography																			
Finalize Appendices																			
Submit Paper for Review																			
Submit Final Paper